

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) Willard Preston Archer			2a. DATE OF DEATH Month January Day 18 Year 69			2b. HOUR 4 PM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH January 24, 1918		6. AGE (In years last birthday) 50 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (State or foreign country) Md		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford Md.			
10. CITY OR TOWN OF DEATH Harford		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Harford Mem. Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Funeral Director		12b. KIND OF BUSINESS OR INDUSTRY Funeral			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md		13b. COUNTY Harford		13c. CITY OR TOWN Fallston		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 203 Connolly Rd	
14. FATHER'S NAME First Walter Middle H. Last Archer			15. MOTHER'S MAIDEN NAME First Loretta Middle Standiford Last (D)						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes, give war or dates of service) WW-11		16b. SOCIAL SECURITY NO. 214-16-9524		17. INFORMANT Address Walter H. Archer, Benson, Maryland 21018					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) C coronary Thrombosis DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Heart Disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 1-12, 1969 , to 1-18, 1969 , that (I) (we) last saw the deceased alive on 1-18, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Dr. U. Monakil, M.D.		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1/18/69			
22d. PHYSICIAN'S NAME (Type) DR. U. MONAKIL, M.D.		22e. ADDRESS 211 N. Union Ave. Havre de Grace, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 21 Jan. 69		23c. NAME OF CEMETERY OR CREMATORY Mountain Christian Church		23d. LOCATION (City or Town) (County) (State) Joppa, Harford Maryland			
24. FUNERAL DIRECTOR Tarring Funeral Home, Aberdeen, Md. 21001				25a. REC'D BY REGISTRAR DATE JAN 21 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

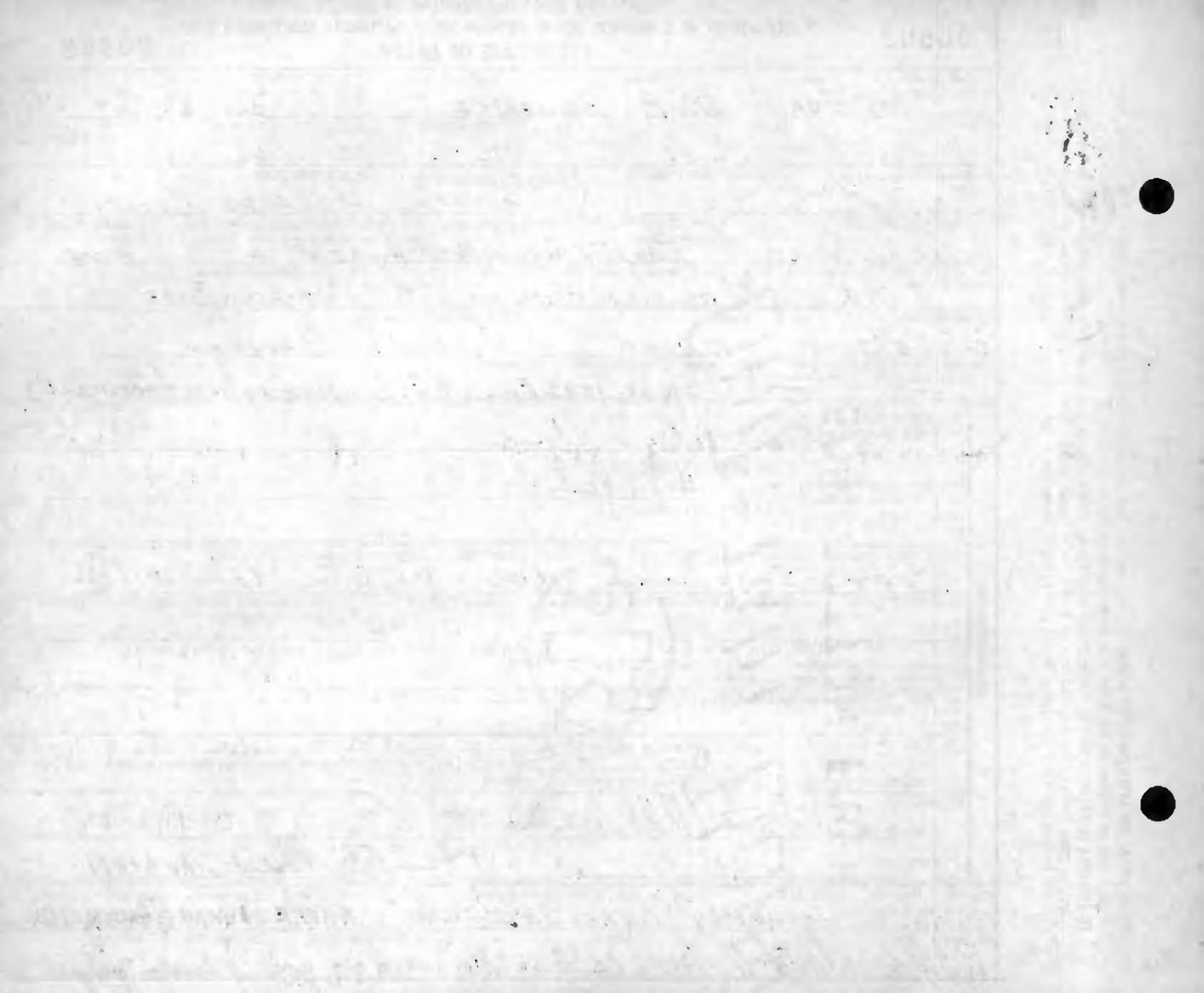
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
1. DECEASED NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF DEATH		2b. HOUR			
James		J.		Bailey				ESTIMATED <input type="checkbox"/> Month Day Year		M			
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD			
Male	White	Nov. 8, 1952		16 YRS		MONTHS DAYS		HOURS MIN.		January 11, 1969 11:50 PM			
7a. BIRTHPLACE (State or foreign county)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH							
Baltimore Md.		U.S.A.				Harford County, Md.							
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY	
Fallston				Fallston Md.				Student					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Maryland				Harford				Fallston				Box #73, Reckord Road	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME									
First Middle Last				First Middle Last									
Jack				Bailey				Katherine B. Lawson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS	
No				None				Mr. Jack Bailey				Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)													
PART 1. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) <u>Fracture neck, Brain Concussion and Hemorrhage</u>													
DUE TO, OR AS A CONSEQUENCE OF													
(b) <u>Auto Accident</u>													
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
				HOUR A.M. P.M. 19									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> IND. WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State							
		Rt 152 Fallston				Rt 152 Fallston Harford Maryland							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE		Philip W. Heuman, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED					
EXAMINER'S NAME (Type)		307 Hickory Ave., Bel Air, Md. 21014				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Jan. 11, 1969					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)					
Burial		1/16/69		Baltimore National				Baltimore Maryland					
24. FUNERAL DIRECTOR						ADDRESS		25. READ BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Leonard J. Ruck Inc. 5305 Harford Road 21214						JAN 14 1969		DATE		[Signature]			

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VR 4-5-64
30M REV. 1-68

00903												DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												00898											
1. DECEASED-NAME (Type or print) First Middle Last MRS EVA MAE BAUBLITZ												2a. DATE OF DEATH Month Day Year Jan. 23, 69												2b. HOUR 6:15 P.M.											
3. SEX FEMALE				4. RACE WHITE				5. DATE OF BIRTH 7-7-1902				6. AGE (In years last birthday) 66 YRS.				7. IF UNDER 1 YEAR MONTHS DAYS				8. IF UNDER 24 HRS. HOURS MIN.															
7a. BIRTHPLACE (State or foreign country) D.C. WASHINGTON				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH HARFORD COUNTY Md.																							
10. CITY OR TOWN OF DEATH HAURE DE GRACE				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) BREVIN NURSING HOME				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSE WIFE				12b. KIND OF BUSINESS OR INDUSTRY HOME																							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.				13b. COUNTY HARFORD ABERDEEN				13c. CITY OR TOWN ABERDEEN				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET AND NUMBER 1 MADISON PLACE																			
14. FATHER'S NAME First Middle Last GEORGE BRUCE BROWN				15. MOTHER'S MAIDEN NAME First Middle Last VIRGINIA PERRYMAN																															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. 2-16-48-4282				17. INFORMANT Address EDNA M. CURRY-1 MADISON PLACE, ABERDEEN MD																											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> 342X DUE TO, OR AS A CONSEQUENCE OF (b) <u>Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Suppurative 2° to dentulous ulcer. Metastatic Parkinson's Dn</u>																																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)																											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State																											
22a. I certify that (I) (this hospital) attended the deceased from _____, 19 65, to _____, 19 69, that (I) (we) last saw the deceased alive on _____, 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																			
22b. SIGNATURE Arnold S. Hunter / P.P. Rodney MD				22c. DATE SIGNED 1/26/69																															
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS 82 Law St, Aberdeen MD 21001																															
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE JAN. 26, 1969				23c. NAME OF CEMETERY OR CREMATORY ANGEL HILL CEM.				23d. LOCATION (City or Town) (County) (State) HAURE DE GRACE HARFORD MD.																							
24. FUNERAL DIRECTOR R. Madwin Mitchell				ADDRESS HAURE DE GRACE MD				25a. REC'D BY REGISTRAR DATE JAN 27 1969				25b. REGISTRAR'S SIGNATURE J. Charles Jones																							



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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
00904		00899	
CERTIFICATE OF DEATH			
1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Darlington		c. LENGTH OF STAY IN 1b 11 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Flintville Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ELLEN Middle L. Last BLACKBURN		4. DATE OF DEATH Month January Day 26 Year 1969	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 17, 1889
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months 79 Days 19 Hours 69 Min.	11. IF UNDER 24 HRS. Months 79 Days 19 Hours 69 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Ash Co., N.C.	
11. BIRTHPLACE (County & State, or foreign country) Ash Co., N.C.		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Noah Long		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Charles D. Blackburn, Darlington, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause pertaining for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Arteriosclerosis and DUE TO 4369 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Frequent Small Cerebrovascular DUE TO 2413 (c) Accident		INTERVAL BETWEEN ONSET AND DEATH 8 yrs 2413	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 17, 1947 to 1/26, 1969 , that (I) (we) last saw the deceased alive on 1/24, 1969 , and that death occurred at 12:30 AM , from causes and on the date stated above.			
22a. SIGNATURE Dudley Phillips		22b. DATE SIGNED Jan. 28, 1969	
22c. PHYSICIAN'S NAME (Type) Dudley Phillips M.D.		22d. ADDRESS Darlington, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 30, 1969	
23c. NAME OF CEMETERY OR CREMATORY Baptist Home		23d. LOCATION (City or Town) (County) (State) Fair Plains, GLC	
24. FUNERAL DIRECTOR JOHN H. HARKINS		25. ADDRESS Delta, Penna.	
25a. DATE JAN 30 1969		25b. REGISTRAR'S SIGNATURE [Signature]	

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FOR STATE HEALTH DEPT.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										00900	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR		
TAMMY SUZANNE BLACKBURN						MATED <input checked="" type="checkbox"/> 1-13 1969			M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD			2d. HOUR
Female	White	Dec. 27, 1968	17 YRS	MONTHS DAYS		HOURS MIN.		January 13, 1969			7:35 M
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
G.M.C. Balto. Co., Md.			U.S.A.						Harford County, Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Rocks			Sharon Road			None			None		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
Maryland			Harford			Rocks			Sharon Road		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
Gary Woodrow Blackburn			Mary Kathryn Hogan								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
No			None			Mary K. Blackburn			Box 122 Jarrettsville, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									21084		
PART 1. DEATH WAS CAUSED BY:									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
IMMEDIATE CAUSE (a) 795X											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
				HOUR A.M. P.M. 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER				22b. DATE SIGNED			
Gerald C. Palmer				Bel Air, Md.				Jan. 13, 1969			
EXAMINER'S NAME (Type)				DEPUTY MEDICAL EXAMINER				ADDRESS (Street, city, town, or county)			
S. Main St., Bel Air, Md. 21014											
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial			1/15/1969		Bel Air Mem. Gardens			Bel Air, Harford, Md.			
24. FUNERAL DIRECTOR						ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Charles E. Kurtz						Jarrettsville, Md.		JAN 16 1969		[Signature]	

0301, 71 - 20000

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1971, 1972, 1973, 1974, 1975, 1976, 1977, 1978, 1979, 1980, 1981, 1982, 1983, 1984, 1985, 1986, 1987, 1988, 1989, 1990, 1991, 1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 26

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR 4-1-64
304M REV. 1-66

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) LONNIE G. BOWMAN			2a. DATE OF DEATH Month January Day 12 Year 1969		2b. HOUR 12:30 a.m. <input type="checkbox"/> p.m. <input checked="" type="checkbox"/>
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH June 27, 1890		6. AGE (In years last birthday) 78 YRS	IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Harford		
10. CITY OR TOWN OF DEATH Aberdeen	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Route #2		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Mail Carrier (Ret.)		12b. KIND OF BUSINESS OR INDUSTRY Post Office
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland	13b. COUNTY Harford	13c. CITY OR TOWN Aberdeen	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER Route #2, Box 131	
14. FATHER'S NAME First Charles Middle C. Last Bowman (D)		15. MOTHER'S MAIDEN NAME First Lucy Middle Gorrell Last (D)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give year or dates of service)		16b. SOCIAL SECURITY NO 220-32-3719		17. INFORMANT Address Agnes Bowman, RD. 2, Aberdeen, Md. 21001	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cerebrovascular DUE TO, OR AS A CONSEQUENCE OF (c) syn					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from June , 19 46 , to Jan , 19 69 , that (I) (we) last saw the deceased alive on Jan 12 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE J. Ralph Horley		22c. DATE SIGNED 1/13/69		22d. PHYSICIAN'S NAME (Type) J. Ralph Horley, M.D.	
22e. ADDRESS Churchville, Maryland 21028		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23b. DATE 14 Jan. 69		23c. NAME OF CEMETERY OR CREMATORY Smith Chapel Meth. Cemetery,		23d. LOCATION (City or Town) (County) (State) Churchville, Md.	
24. FUNERAL DIRECTOR Tarring Funeral Home. Aberdeen, Md. 21001		25a. REC'D BY REGISTRAR JAN 15 1969		25b. REGISTRAR'S SIGNATURE [Signature]	

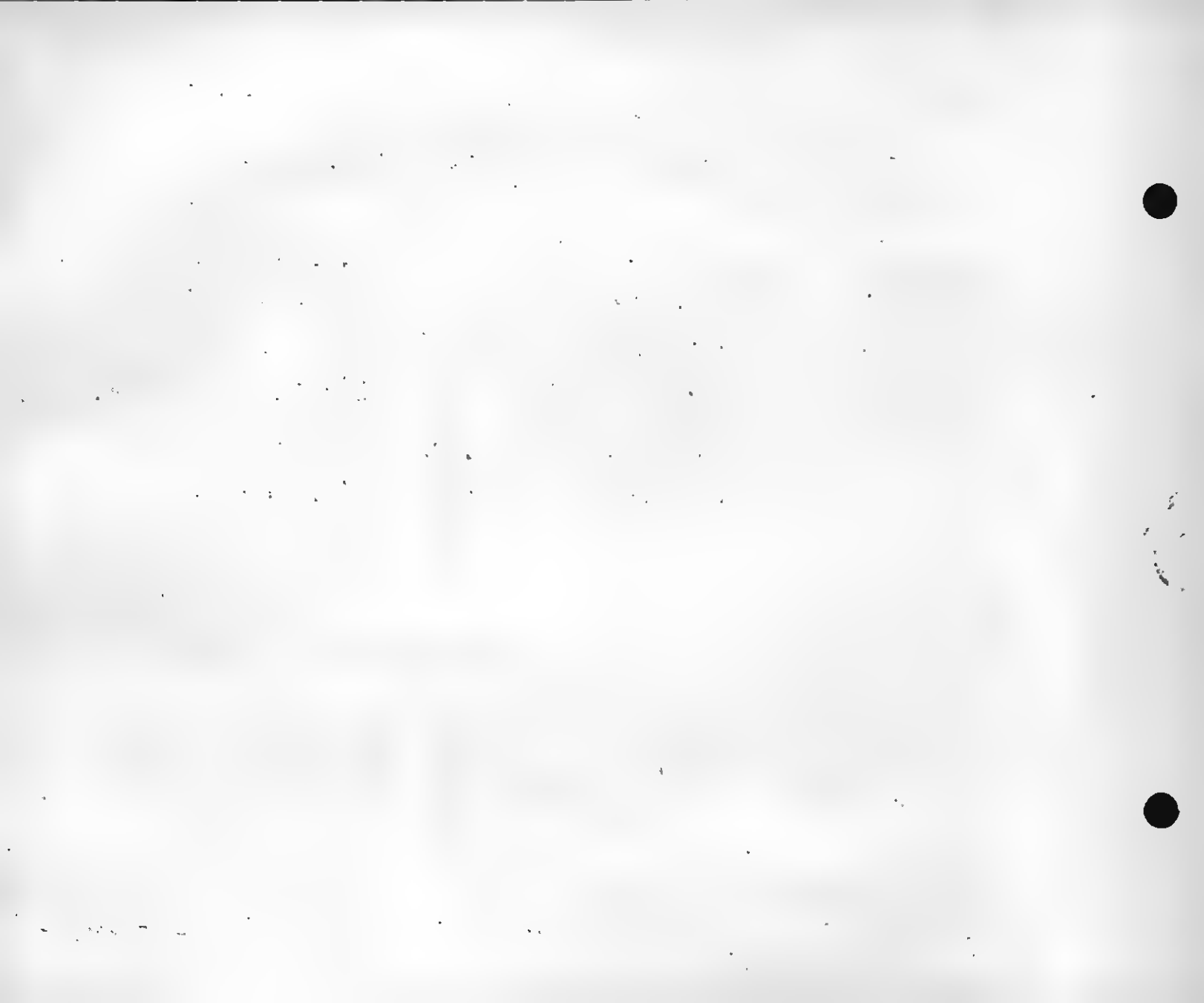


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

VR A (5-6)
30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH		2b. HOUR		
CHARLE EDWARD BROOKS						JAN. 19, 1969 Month Day Year		8A. M		
3. SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years lost birthday)		7 FUNERAL YEAR		
MALE		WHITE		FEB. 10, 1887		81 YRS.		MONTHS DAYS HOURS MIN		
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
BALTO. MD.		U.S.A.				HARFORD Md.				
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
HAYRE DE GRACE			620 CT SEGO, ST.			GAS STATION OPERATOR		RETIRED		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
MD.			HARFORD		HAYRE DE GRACE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		620 CT SEGO, ST.	
14 FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
CHARLES CARROLL BROOKS			MARY JANE			ARNOLD				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO - A			17 INFORMANT				
			652-32-9903			MRS. NELLIE S. BROOKS, Address 620 CT SEGO ST. HAYRE DE GRACE MD.				
18 CAUSE OF DEATH (Enter only one cause per line of (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u>										
4319 DUE TO, OR AS A CONSEQUENCE OF <u>Arterio-Sclerosis-Cardiac</u>										
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost.										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
					YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
		HOUR A.M. Month Day Year								
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State						
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										
22a. I certify that (I) (this hospital) attended the deceased from <u>MAY 15, 1968</u> , to <u>JAN 19, 1969</u> , that (I) (we) lost saw the deceased alive on <u>JAN 15, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE				DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED		
<u>A.L. Lewis M.D.</u>								JAN. 20, 1969		
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS						
A.L. LEWIS M.D.				HAYRE DE GRACE MD						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
BURIAL		JAN. 21, 1969		ANGEL HILL CEM.		HAYRE DE GRACE HARFORD MD				
24. FUNERAL DIRECTOR		ADDRESS		25a. DEC. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
R. Madison Mitchell		HAYRE DE GRACE MD.		JAN 22 1969		[Signature]				





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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR
Roland				Clark		Month Jan Day 2 Year 1969			2330 M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		7. UNDER 1 YEAR	8. UNDER 24 HRS.
Male		Cau		9 Jun 36		32 YRS.		MONTHS	DAYS
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Ohio		USA				Harford Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Edgewood			6533 B Hawthorne Drive			Soldier		U.S. Army	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Maryland			Harford		Edgewood		YES		6533 B Hawthorne Drive
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
Allen					Clark	Margaret			Hamilton
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
Yes			1954-1969		276-30-8705 Personnel Office, Edgewood, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Interstitial pneumonitis diffuse, bilateral</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(b) <u>Cardiomegaly with with right and left ventricular</u>									
DUE TO, OR AS A CONSEQUENCE OF <u>hypertrophy</u>									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		No		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No City or Town County State					
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>									
22a. I certify that (I) (the hospital) attended the deceased from <u>2 Jan</u> , 19 <u>69</u> , to <u>2 Jan</u> , 19 <u>69</u> , that (I) (we) lost the deceased alive on <u>2 Jan</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					22c. DATE SIGNED				
<u>John M. Dent CPT, MC</u>					3 Jan 69				
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
JOHN M DENT, CPT, MC					Edgewood Dispensary, Edgewood Ars, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		1-7-69		Post Cemetery		Aberdeen Proving Gnd.		Md.	
24. FUNERAL DIRECTOR					25a. REG'D BY REGISTRAR				
<u>FRANK J. CRITCHFIELD</u>					JAN 7 1969				

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) First Middle Last Cora C. Comer			2a. DATE OF DEATH Month Day Year 1 16 69			2b. HOUR 9:40 AM	
3 SEX F		4. RACE W		5. DATE OF BIRTH June 1, 1890		6. AGE (In years last birthday) 78 YRS	
7a. BIRTHPLACE (State or foreign country) Va		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford Md	
10 CITY OR TOWN OF DEATH Harford, Md		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Harford Memorial		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Pennsylvania		13b. COUNTY York		13c. CITY OR TOWN Delta		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER RD 2		14 FATHER'S NAME First Middle Last Unknown		15 MOTHER'S MAIDEN NAME First Middle Last Belle Cornett			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO 224-05-6038		17 INFORMANT Stephen F. Comer		Address 1117 21st Harford	
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis DUE TO, OR AS A CONSEQUENCE OF (b) Divided atherosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL, BETWEEN ONSET AND DEATH 1 hr 54/15
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or RFD No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 1/11, 1968, to 1/16, 1969, that (I) (we) lost the deceased alive on 1/16, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Dudley Phillips				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE/SIGNED 1/17/69	
22d. PHYSICIAN'S NAME (Type) Dudley Phillips				22e. ADDRESS DARLINGTON MD 21031			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Jan. 19, 1969		23c. NAME OF CEMETERY OR CREMATORY Mt. Noto Cemetery		23d. LOCATION (City or Town) (County) (State) Delta, York, Md	
24 FUNERAL DIRECTOR John H. Harkins				ADDRESS Delta, Pa.		25a. REGISTRATION JAN 21 1969	

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR			
John H. Darney						Month 1 Day 31 Year 69			8:30 A M			
3 SEX		4 RACE		5 DATE OF BIRTH			6 AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
M		W		9-13-1912			56 YRS		MONTHS DAYS		HOURS MIN	
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			
md			USA						Hartford Md			
10. CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
Havre de Grace				Hartford Memorial				Carpenter				
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE				13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER		
Md.				Hartford		Joppa		YES <input type="checkbox"/> NO <input type="checkbox"/>		2515 Jerusalem Rd.		
14 FATHER'S NAME				15 MOTHER'S MAIDEN NAME								
First Middle Last				First Middle Last								
Frederick Charles Darney				Dorthea Diller								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, (specify when) (If yes give no. of service)				16b SOCIAL SECURITY NO		17 INFORMANT		Address				
Yes W.W.II				217-18-8075		Mrs. Label Darney		2515 Jerusalem Road				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Generalized Carcinomatosis												
DUE TO, OR AS A CONSEQUENCE OF (b) Retro-peritoneal mass -												
DUE TO, OR AS A CONSEQUENCE OF (c) etiology undetermined												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
1/17/69			Obstruction & Hemorrhage			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
			HOUR A.M. Month Day Year P.M. 19									
21a INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21a. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION			City or Town County State			
						Street or R.F.D. No.						
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 1/31/69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b SIGNATURE						22c DATE SIGNED						
Charles J. Foley Jr.						FEB 5 1969						
22d PHYSICIAN'S NAME (Type)						22e ADDRESS						
Charles J. Foley Jr.						Havre de Grace, Md						
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE		23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)				
Burial			2-2-1969		St. Stephens Cemetery			Bradshaw Baltimore Md.				
24. FUNERAL DIRECTOR						25a REC'D BY REGISTRAR			25b REGISTRAR'S SIGNATURE			
Lassahn Funeral Home 7401 Belair Road 21236						FEB 5 1969			William J. Jones			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

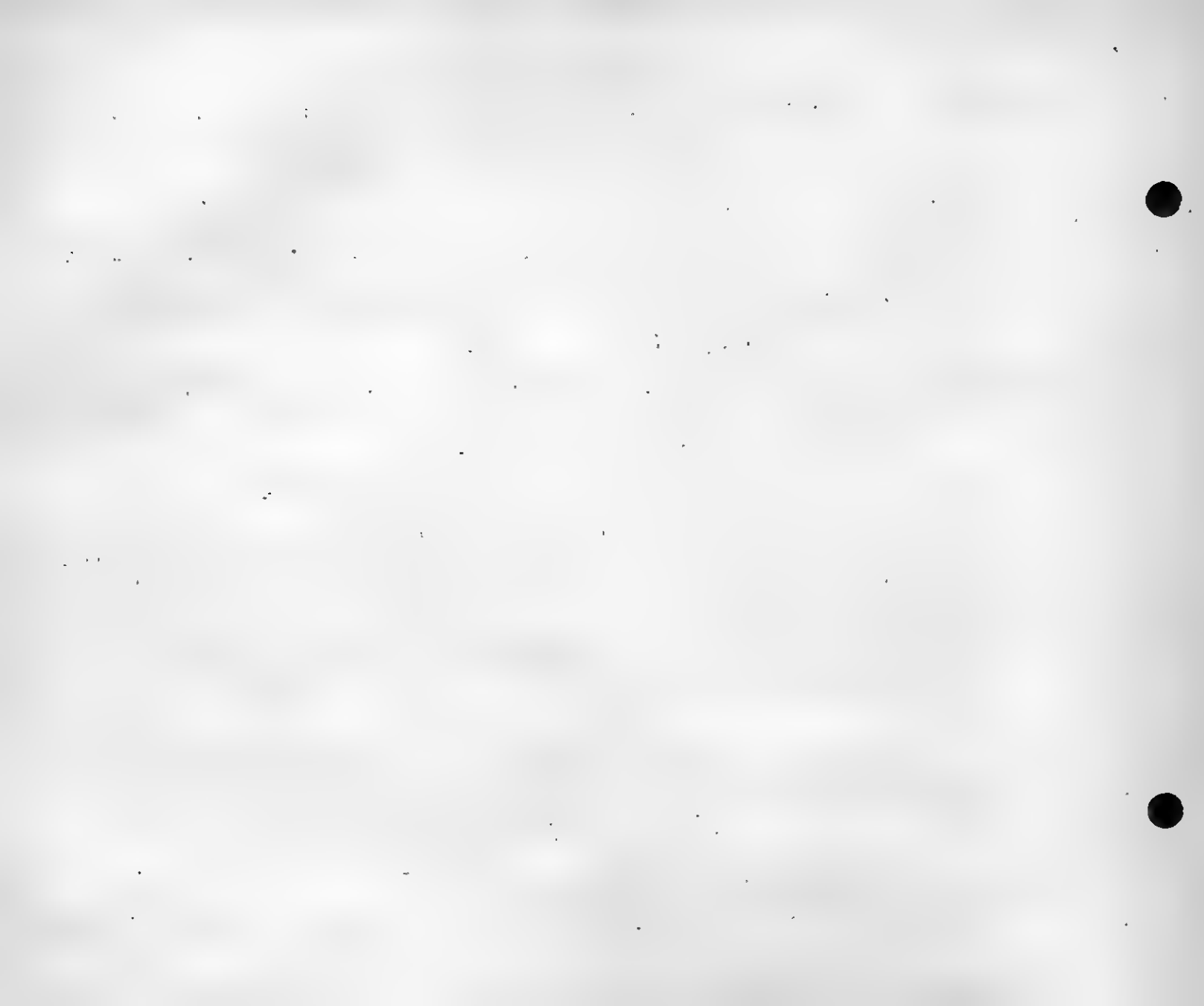
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

10912

00907

1 DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR		
CLARENCE		E.	DORSEY		January 18 1969		8:25 M		
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER YEAR		
Male	Negro		August 31, 1890		78 YRS		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		U.S.A.				Harford Md			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Aberdeen		Bush Chapel Road		Baggage Agent (Ret.)		Railroad			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Harford		Aberdeen				Bush Chapel Road	
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last					
Fred Dorsey (D)				Unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)				16b. SOCIAL SECURITY NO.		17. INFORMANT Address			
No				717-07-5504		Margaret Dorsey, Aberdeen, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4124 Cardio Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Bronchiolitis with Pulmonary Emphysema</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic Cardiovascular disease</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Gastroduodenitis with Intractable Hiccough</u> (b) <u>Cerebral Thrombosis with Left Hemi paresis</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>9/26</u> , 19 <u>64</u> , to <u>1/18</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>1/18</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>George T. Stansbury, M.D.</u> DEGREE				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>1/21/69</u>			
22d. PHYSICIAN'S NAME (Type) George T. Stansbury, M.D.				22e. ADDRESS 569 Revolution St. Havre de Grace, Md.					
23a. BURIAL, CREMATION, REMOVA. (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		22 Jan. 69		Mt. Calvary Cemetery		Aberdeen, Harford Co. Maryland			
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Tarring Funeral Home, Aberdeen, Md. 21001				JAN 23 1969					



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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
00913 CERTIFICATE OF DEATH 00908									
1. PLACE OF DEATH a. COUNTY Harford MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forest Hill					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forest Hill				
c. LENGTH OF STAY IN 1b 26 yrs.					d. STREET ADDRESS Jarrettsville Road				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Jarrettsville Road					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Sarah First Jane Middle Fender Last					4. DATE OF DEATH Month January Day 5 Year 1969				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 27, 1882		9. AGE (In years last birthday) 86 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Home			11. BIRTHPLACE (County & State, or foreign country) Sparta, N. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Melvin Edwards					14. MOTHER'S MAIDEN NAME Martha Crouse				
15. WAS DECEASED EVER IN U.S. ARMY OR FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) ---					16. SOCIAL SECURITY NO. 118-54-4336 Informant Jane Warfield Address Box 56 Forest Hill, Md. 21050				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO (b) Epidemic Flu DUE TO (c) 471X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									INTERVAL BETWEEN ONSET AND DEATH 2 days 5 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Sept. 29 , 19 51 , to Jan. 5 , 19 69 , that (I) (we) last saw the deceased alive on Jan. 5 , 19 69 , and that death occurred at 9 P.M. from the causes and on the date stated above.									
22a. SIGNATURE Robert Barthel					22b. DATE SIGNED Jan. 6/69				
22c. PHYSICIAN'S NAME (Type) Robert Barthel					22d. ADDRESS Forest Hill, Maryland 105 W. Jarrettsville Rd.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 1/8/1969		23c. NAME OF CEMETERY OR CREMATORY Mt. Zion		23d. LOCATION (City, town or county) (State) Fountain Green, Md.		
24. FUNERAL DIRECTOR Charles E. Kurtz Jarrettsville, Md.					25a. REC'D BY REGISTRAR JAN 7: 1969				
					25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>				

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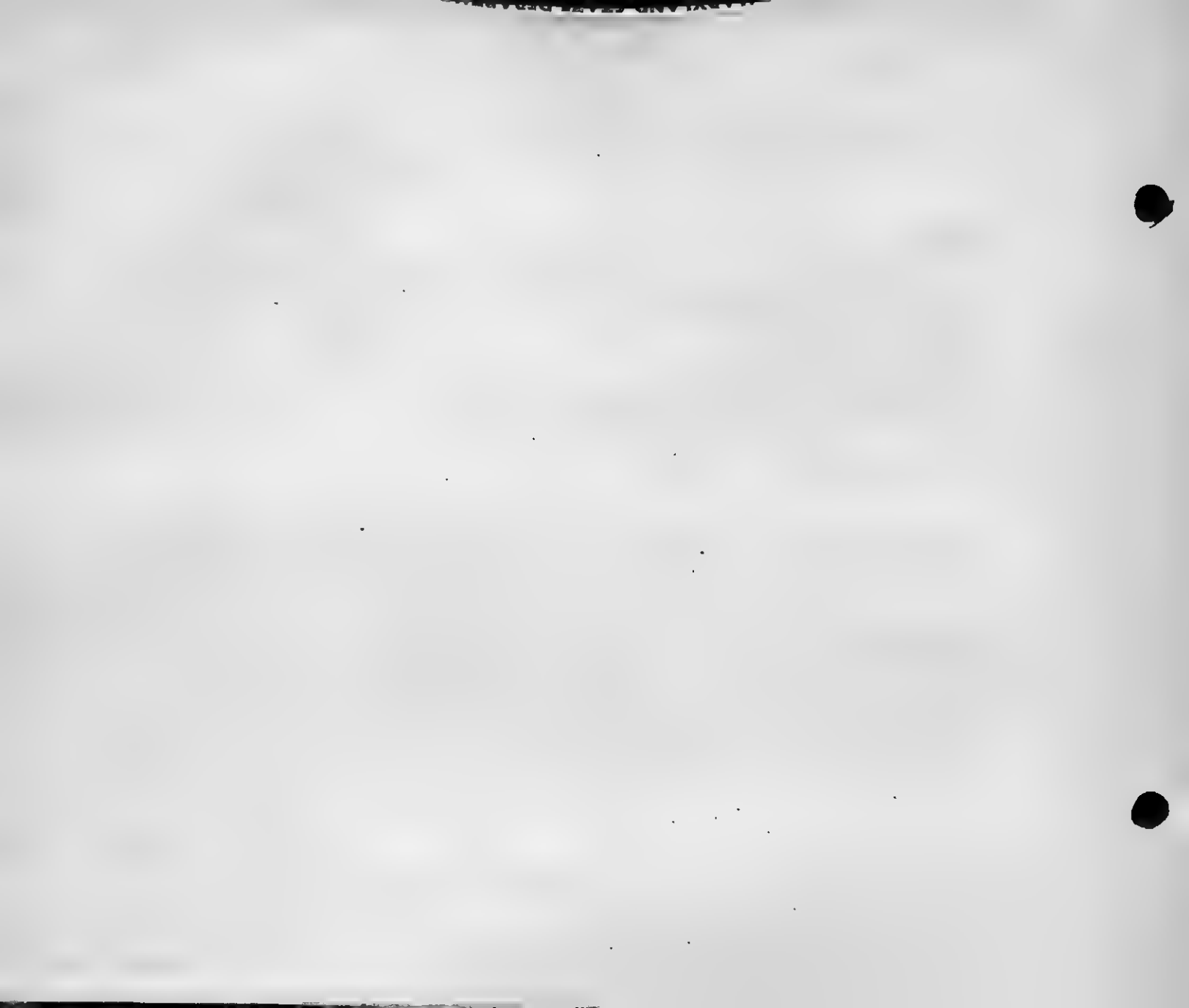
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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print) Carrie Eleanor Fox						2a. DATE OF DEATH Month January Day 22 Year 1969			2b. HOUR 2:30 MIN A			
3. SEX Female		4. RACE White		5. DATE OF BIRTH 8/22/1893		6. AGE (In years last birthday) 75 YRS		7. UNDER YEAR MONTHS 75 DAYS		8. UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) Md		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Hartford						
10. CITY OR TOWN OF DEATH Havre de Grace				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Hartford Mem Hosp				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Same		
13a. USUAL RESIDENCE (Where deceased lived, if institut on, Residence before admission) STATE Md				13b. COUNTY Hartford		13c. CITY OR TOWN Havre de Grace		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 658 Otsego St.		
14. FATHER'S NAME First Linwood Middle L. Last Heedon				15. MOTHER'S MAIDEN NAME First Carrie Middle Ella Last Boyd								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No				16b. SOCIAL SECURITY NO Yes		17. INFORMANT Mr Fred Fox		Address 1208 Perryman Rd				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction												
4100 DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Thrombosis												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) Arteriosclerotic Cardiovascular Disease												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Hypertension and Calcific Aortic Sklerosis												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)				21f. LOCATION Street or R.F.D. No		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from 1-21 , 19 69 , to 1-22 , 19 69 , that (I) (we) last saw the deceased alive on 1-22 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Dante U. Monakil, M.D. DEGREE M.D.						ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 1-22-69				
22d. PHYSICIAN'S NAME (Type) DANTE U. MONAKIL, M.D.						22e. ADDRESS 211 N. Union Ave. Havre de Grace, Md.						
23a. BURIAL, CREMATION, REMOVA. (Specify)		23b. DATE 1/25/69		23c. NAME OF CEMETERY OR CREMATORY Angel Hill Cemetery		23d. LOCATION (City or Town) Havre de Grace		County Hartford		State Md.		
24. FUNERAL DIRECTOR Winnington Co. Harold Grace, Md.						ADDRESS		25. JUAN 24 1969		26. REGISTERED SIGNATURE James Judge		

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY HARFORD b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL-DARLINGTON c. LENGTH OF STAY IN 1b LIFE d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) R.D. #1 Box 115						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MD b. COUNTY HARFORD c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL-DARLINGTON d. STREET ADDRESS R.D. #1 Box 115 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First MARY Middle ANDREW Last GEORGE						4. DATE OF DEATH Month JAN. Day 7 Year 1969					
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH FEB. 5, 1925		9. AGE (In years last birthday) 43 yrs.		10. IF UNDER 1 YEAR Months 4 Days 1 Hours 1 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER				10b. KIND OF BUSINESS OR INDUSTRY FARM		11. BIRTHPLACE (County & State, or foreign country) MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME JOHN EVANS GEORGE						14. MOTHER'S MAIDEN NAME ANNIE J. ANDREW					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. 1126		17. INFORMANT ANNIE T. GEORGE Address DARLINGTON, MD. R.D. #1				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Branchiopneumonia 1126 DUE TO Conditions, if any, which gave rise to immediate cause (b) Pulmonary Metastases (a), stating the underlying cause last. (c) Melanosarcoma - on the back PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 3-6 mos 2 1/2 yrs	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1966 to Jan. 1969 , that (I) (we) last saw the deceased alive on 1/20 19 68 and that death occurred at 11/8/69 M, from the causes and on the date stated above.											
22a. SIGNATURE W.H. Sadowsky						22b. DATE SIGNED 1/8/69		22c. PHYSICIAN'S NAME (Type) W.H. SADOWSKY		22d. ADDRESS 504 LEWIS ST. HANDED GING MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF JAN 10, 1969		23c. NAME OF CEMETERY OR CREMATORY DARLINGTON CEM.		23d. LOCATION (City, town or county) (State) DARLINGTON HARFORD Co. MD.		24. FUNERAL DIRECTOR'S SIGNATURE R. Madison Mitchell ADDRESS HAYRE DE GRACE, MD.		25a. RECD BY REGISTRAR JAN. 13 1969 25b. REGISTRAR'S SIGNATURE [Signature]	



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR			
SHERMAN		E.	GILBERT		January 2, 1969		1:05 P.M.			
3 SEX	4 RACE		5 DATE OF BIRTH		6 AGE (in years last birthday)		7 UNDER 1 YEAR			
Male	White		DEC 7, 1906		62 YRS.		MONTHS DAYS HOURS MIN			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
ILL		U.S.				HARFORD Md				
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		2b KIND OF BUSINESS OR INDUSTRY				
HAUGS de GRACE		HARFORD MEMORIAL		MAINTENANCE		U.S. GOV.				
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INS DE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER		
md		Cecil		Rising Sun						
14 FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last	
EDWARD				GILBERT	LARA				CARTER	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		(If yes give war or dates of service)		16b SOCIAL SECURITY NO		17 INFORMANT Address				
NO				578-05-2934						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4109 Acute Myocardial Infarction. DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Occlusion. DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic Cardiovascular Disease. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, FARM STREET, FACTORY, OFFICE BUILDING, ETC)			21f LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from January 2, 1969, to January 2, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE DANTE U. MONAKIL, M.D.			DEGREE			ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED 1/2/69		
22d PHYSICIAN'S NAME (Type) DANTE U. MONAKIL, M.D.			22e ADDRESS 211 N. Union Ave. Harford, Md.							
23a BURIAL CREMATION, REMOVAL (Specify) BURIAL			23b DATE 1/5/69		23c NAME OF CEMETERY OR CREMATORY HOPEWELL		23d LOCATION (City or Town) (County) (State) PORT DEPOSIT, CECIL, MD.			
24 FUNERAL DIRECTOR RALPH M REED			ADDRESS RALPH M REED			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE Charles Judge		
						DATE JAN 6 1969				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00912

1 DECEASED NAME (Type or print) Mary Grove Graeser			2a. DATE OF DEATH Month 1 Day 31 Year 69			2b. HOUR 12 noon			
3 SEX F		4 RACE White		5. DATE OF BIRTH 12 March 1909		6 AGE (In years last birthday) 59 YRS.			
7a BIRTHPLACE (State or foreign country) md		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Hartford			
10 CITY OR TOWN OF DEATH Havre de Grace			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Hartford Memorial			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Beautician			
13a USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE md COUNTY Cecil			13b CITY OR TOWN Port Deposit		13c INSIDE CITY, MTS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 19 High St.		
14. FATHER'S NAME First John Middle Earl Last Tyson			15. MOTHER'S MAIDEN NAME First Elizabeth Middle Tosh Last Tosh						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) No (If yes give war or dates of service)			16b SOCIAL SECURITY NO 218-09-0978		17. INFORMANT Oliver Wm. Graeser, Port Deposit, Md.				
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART 1 DEATH CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of Liver 1978 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21a INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f LOCATION Street or RFD No City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 1-30, 1969 , to 1-31, 1969 , that (I) (we) last saw the deceased alive on 1/31/69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE A.W. Grigoleit MD					DEGREE M.D.		22c. DATE SIGNED 1/31/69		
22d PHYSICIAN'S NAME (Type) A.W. GRIGOLEIT M.D.					22e ADDRESS HAVRE DE GRACE Maryland				
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 5 Feb. 69		23c NAME OF CEMETERY OR CREMATORY Arlington National Cemetery, Ft Myer, Virginia		23d LOCATION (City or Town) (County) (State)			
24 FUNERAL DIRECTOR Tarring Funeral Home, Aberdeen, Md. 21001					ADDRESS		25a REC'D BY REGISTRAR Charles Judge		
					DATE FEB 4 1969		25b REGISTRAR'S SIGNATURE		

CERTIFICATE OF DEATH

2013

1 DECEASED NAME (Type or print) John Clinton Graybeal			2a DATE OF DEATH Month 1 Day 30 Year 69			2b HOUR 10A	
3 SEX M		4 RACE W		5 DATE OF BIRTH Nov. 3, 1883		6 AGE (In years last birthday) 85 YRS	
7a BIRTHPLACE (State or foreign country) N.E.		7b CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford Md	
10 CITY OR TOWN OF DEATH Harve de Grace			11 NAME OF HOSPITAL OR LAST TOWN (If not in hospital give street address) Harford Memorial			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Farmer	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE md			13b CITY OR TOWN Fallston			13c STREET AND NUMBER Rt #1 Box 345	
14 FATHER'S NAME Peter Graybeal			15 MOTHER'S MAIDEN NAME Katherine Hardin				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) No			16b SOCIAL SECURITY NO 220-34-6978		17 INFORMANT Mrs. Blanche E. T. Graybeal		
			Address RD #1 Box 345 Fallston, Md. 21047				
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))							
PART 1 DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) Bacteremia							
DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia & Cystitis							
DUE TO, OR AS A CONSEQUENCE OF (c) Bleeding Prostate Gland							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Arteriosclerosis Cardiovascular Disease - Senility							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING ETC		21f LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE Dr. D. U. Monakill				22c DATE SIGNED 1/30/69		22d PHYSICIAN'S NAME (Type) D. U. MONAKILL	
23a BURLINGHAM, CREMATION, REMOVAL (Specify) Burial		23b DATE 2/2/1969		23c NAME OF CEMETERY OR CREMATORY Bel Air Mem. Gardens		23d LOCATION (City or Town) (County) (State) Bel Air, Harford, Maryland	
24 FUNERAL DIRECTOR Charles E. Kurtz				ADDRESS Jarrettsville, Md. 21084		25a RECEIVED BY REGISTRAR FEB 4 1969	
				25b REGISTRAR'S SIGNATURE J. Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove cases on papers. Pages 1 and 2 should be filed with the State Health Department at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 19. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P-103. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV 7/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print) JOSEPH EDWIN GREEN		2a DATE KNOWN OF DEATH <input type="checkbox"/> Month <input checked="" type="checkbox"/> JAN 24 1969		2b HOUR <input type="checkbox"/> M <input type="checkbox"/> A <input type="checkbox"/> P
3 SEX MALE	4 RACE WHITE	5 DATE OF BIRTH FEB 1, 1908	6 AGE (In years last birthday) 60 YRS	7c IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>
7a BIRTHPLACE (State or foreign country) VIRGINIA		7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH HARFORD
10 CITY OR TOWN OF DEATH JARRETTSVILLE		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) FURNACE Rd	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HORSE-TRAINER-OWNER RACING	12b KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD		13b COUNTY PRINCE GEORGES	13c CITY OR TOWN LAUREL	13d INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO
14 FATHER'S NAME First FRANK Middle GREEN Last UNKNOWN		15 MOTHER'S MAIDEN NAME First UNKNOWN Middle UNKNOWN Last UNKNOWN		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16b SOCIAL SECURITY NO 115-14-8630		17 INFORMANT MRS. EDNA M. GREEN
18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARBON MONOXIDE ASPHIXIATION 7520 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) SUICIDE DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b TIME OF INJURY Month, Day, Year JAN 24, 69	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18) HOSE EXHAUST PIPE TO CAR	
21d INJURY OCCURRED WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) CAR-FURNACE Rd	21f LOCATION Street or R.F.D. No FURNACE City or Town JARRETTSVILLE County HARFORD State MD		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE Philip W. Heuman		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b DATE SIGNED JAN 24, 69
EXAMINER'S NAME (Type) PHILIP W. HEUMAN, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
		ADDRESS (Street, city, town or county) 307 HICKORY AVE BEL AIR, MD.		
23a BURIAL, CREMATION REMOVAL (Specify) BURIAL	23b DATE 1/27/1969	23c. NAME OF CEMETERY OR CREMATORY WARRENTON	23d. LOCATION (City or Town) (County) (State) WARRENTON, PAUQUET, VA.	
24 FUNERAL DIRECTOR CHARLES E. KURTZ		ADDRESS JARRETTSVILLE, MD		25a REC'D BY REGISTRAR JAN 27 1969
				25b REGISTRAR'S SIGNATURE Charles E. Kurtz

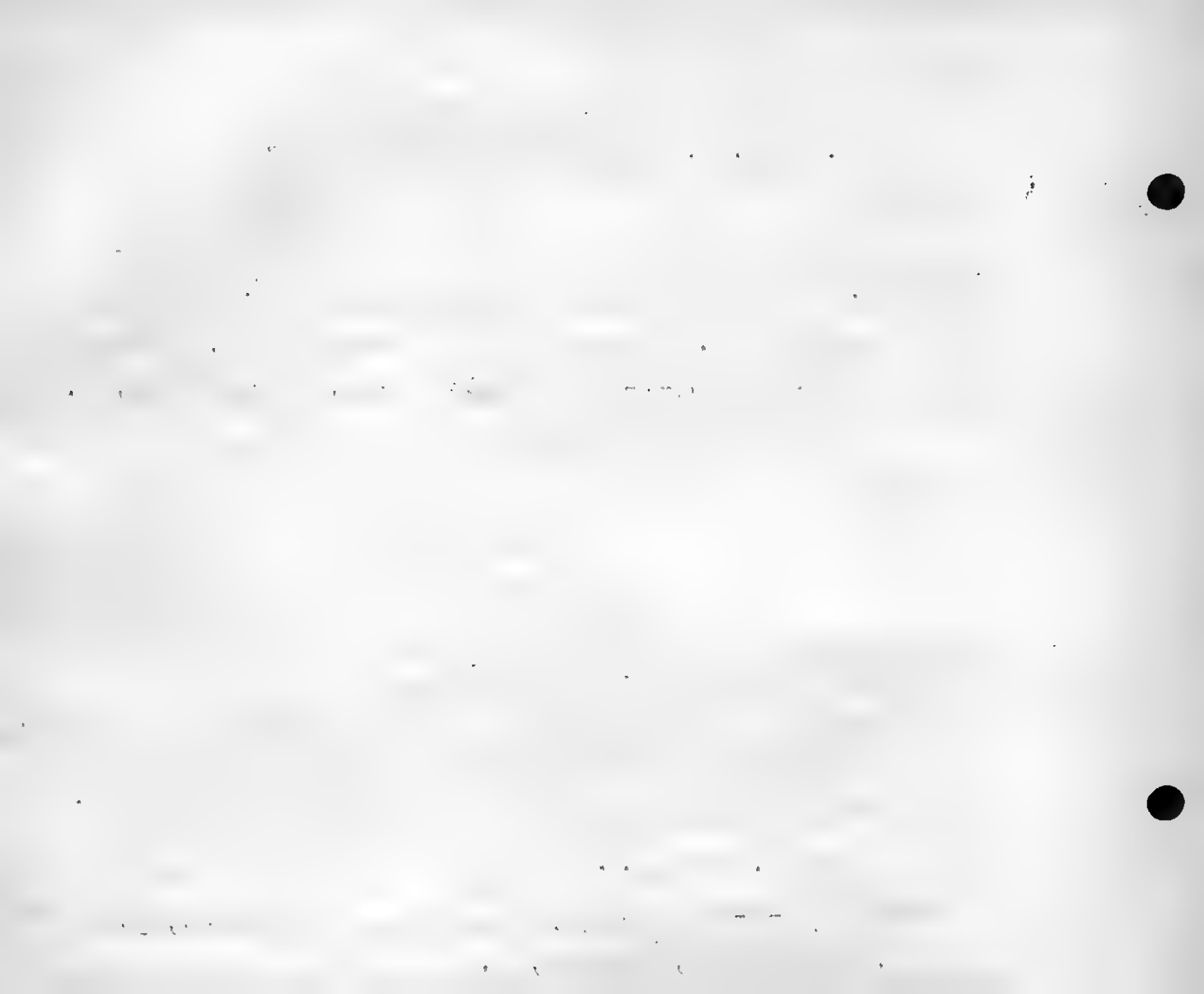
21084

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 21 Film 409 2-10-69 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 00920 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 00915											
1. DECEASED NAME (Type or Print) Mary Ellen Hasson						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> 1-22-1969		2b. HOUR 1:20 PM			
3 SEX Female	4 RACE Cau.	5 DATE OF BIRTH Dec. 15, 1886	6 AGE (in years last birthday) 82 YRS	7 UNDER 24 HRS MONTHS DAYS HOURS MIN.	8 IF UNDER 24 HRS	2c. DATE PRONOUNCED DEAD January 22, 1969		2d. HOUR 1:20 PM			
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CIT. ZEN. OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford		Md			
10. CITY OR TOWN OF DEATH Havre de Grace		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Harford Memorial Hospital		12a. USJA. OCCUPATION (Kind of work done during most of working life, even if retired.) House Wife		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USJA. RESIDENCE (Where deceased lived, if institution residence before admission) STATE Md.		13b. COUNTY Cecil		13c. CITY OR TOWN Port Deposit		13d. INSIDE CITY LIM. 75' YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 128 S. Main			
14. FATHER'S NAME First John W. Middle W. Last Founds				15. MOTHER'S MAIDEN NAME First Hannah E. Middle E. Last Murphy							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO 219-18-9505		17. INFORMANT Hospital Records, Havre de Grace, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Fracture Right Femur DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day Year Nov. 1968 HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18) Fell							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home		21f. LOCATION Street or R.F.D. No. Port Deposit, Cecil		City or Town Cecil County Md. State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Gerald C. Palmer		EXAMINER'S NAME (Type) Gerald C. Palmer, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED 1-23-69					
23a. B. RIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE 1-25-69		23c. NAME OF CEMETERY OR CREMATORY Asbury Cemetery		23d. LOCATION (City or Town) (County) (State) Port Deposit, Cecil, Md.					
24. FUNERAL DIRECTOR Lee A. Patterson & Son, Perryville, Md.				25a. REG. STAMP FEB 3 1969		25b. REGISTRAR'S SIGNATURE					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 154
45M 1569

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
0092-1									
00316									
1. DECEASED-NAME (Type or print) Charles Winton Hudler			2a. DATE OF DEATH January 15 1969			2b. HOUR 9:55 A.M.			
3. SEX Male		4. RACE White		5. DATE OF BIRTH Feb. 6, 1893		6. AGE (in years or birthday) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) N.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford Md.			
10. CITY OR TOWN OF DEATH Harrode de Geance		11. NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address) Harford Mem. Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Farmer Ret.		12b. KIND OF BUSINESS OR INDUSTRY Farm			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b. COUNTY Ceel		13c. CITY OR TOWN North East		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Box 106 RD #1	
14. FATHER'S NAME James W. Hudler			15. MOTHER'S MAIDEN NAME Elizabeth — Blenkins						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes no, or unknown			16b. SOCIAL SECURITY NO. 218-18-1240		17. INFORMANT Mrs. Chas. W. Hudler North East, R.D.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>cerebrovascular accident</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days 14 days	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work or work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from 12-27-1968, to 15 JAN, 1969, that (I) (we) lost saw the deceased alive on 15 JAN 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Neil R. Taylor				DEGREE M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 1-16-69	
22d. PHYSICIAN'S NAME (Type) Neil R. Taylor M.D.		22e. ADDRESS							
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 1-18-1969		23c. NAME OF CEMETERY OR CREMATORY Conowingo Baptist		23d. LOCATION (City or Town) (County) (State) Conowingo Ceel Md.			
24. FUNERAL DIRECTOR E. McAllen		ADDRESS Rising Sun, Md.		25a. REC'D BY REGISTRAR JAN 17 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print)		First	Middle	Last	2a DATE KNOWN OF ESTI- DEATH MATED	Month	Day	Year	2b HOUR
MICHAEL			--	KOZUB	<input checked="" type="checkbox"/> Jan. 29 1969				M
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	2c DATE PRONOUNCED DEAD	Month	Day	Year	2d HOUR
Male	White	June 30, 1893	75 YRS		Jan. 29 1969				4 PM
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
Austria	USA			Harford		Md.			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY			
Havre de Grace		DOA - Harford Memorial Hospital		Machinist		Shipbldg.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER	
Md.		Harford		Abingdon				320 Hooker Mill Road	
14 FATHER'S NAME		First	Middle	Last	15 MOTHER'S MAIDEN NAME		First	Middle	Last
Alexander		--		Kozub	Mary		--		Skovranek
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		(If yes give year or dates of service)		16b SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
Yes		WWI		217-18-2639		Michael J. Kozub, 320 Hooker Mill Road, Abingdon, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arterio sclerotic CVD</u> <u>4124</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County	State
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)		22b DATE SIGNED					
<u>Gerald C. Palmer</u>		Gerald C. Palmer, M.D.		Jan. 30, 1969					
23a. BURIAL, CREMATION REMOVAL (Specify)		23b DATE		23c. NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)	(State)
Burial		Feb. 1, 1969		Bel Air Memorial Gardens		Bel Air		Harford	Md.
24 FUNERAL DIRECTOR ADDRESS				25a REC'D BY REGISTRAR DATE		25b REBURY AS AT J.			
Howard K. McComas & Son, Abingdon, Md.				FEB 3 1969					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print)		First		Middle		Last		2c. DATE OF DEATH			2b. HOUR
EDWARD DAVID LABRENZ								JAN. 24 1969			11:30 P
3. SEX	4. RACE		5. DATE OF BIRTH			6. AGE (in years last birthday)		7. UNDER 1 YEAR		8. UNDER 24 HRS	
MALE	White		October 7, 1894			74 YRS		MONTHS		DAYS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. COUNTY OF DEATH		Md	
Pittsburgh, PENNSYLVANIA		U.S.A.		WIDOWED		DIVORCED		HARFORD Co.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
HARFORD de Grace			HARFORD Memorial Hosp.			Installation			Elevator		
13a. USUAL RESIDENCE (Where deceased lived, if institution on Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
MARYLAND			HARFORD		Bel Air		YES		102 W. Belcrest Rd.		
14. FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME		
August							Labrenz		Mary Katchska		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT		102 West Belcrest Road		Address		
YES			66-1		335-10-3482A		Mrs. Ruth H. Labrenz		Bel Air, Maryland 21014		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) cardiac Decompensation											
4124 DUE TO, OR AS A CONSEQUENCE OF											
(b) Arteriosclerotic Cardiovascular Disease											
DUE TO, OR AS A CONSEQUENCE OF											
(c) Generalized Arteriosclerosis											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
Pulmonary Emphysema											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
						YES			NO		
21a. ACCIDENT WAS UNDERLYING			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			HOUR A.M. Month Day Year								
(If either, notify medical examiner)			P.M. 19								
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING ETC)			21f. LOCATION			Street or R.F.D. No City or Town County State		
White <input type="checkbox"/> Not white <input type="checkbox"/>											
at work <input type="checkbox"/> at work <input type="checkbox"/>											
22a. I certify that (I) (this hospital) attended the deceased from 1-23, 1969, to 1-24, 1969, that (I) (we) last saw the deceased alive on 1-24, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE						22c. DATE SIGNED					
Dante H. Monakil, M.D.						1/25/69					
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
DANTE H. MONAKIL, M.D.						211 N. Union Ave.			Harford de Grace, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			Jan. 27, 1969			Mt. Zion Meth. Ch Cem.			Bel Air, Harford Co., Maryland 21014		
24. FUNERAL DIRECTOR						ADDRESS			25. RECD BY REGISTRY		
Joseph William Foster						W. Broadway & Williams St.			JAN 28 1969		
Bel Air, Maryland 21014									26. REGISTRAR'S SIGNATURE		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
919										
1 DECEASED-NAME (Type or print) <i>Rosa Mae Lee</i>			2a DATE OF DEATH Month <i>January</i> Day <i>14</i> Year <i>1969</i>			2b HOUR <i>6:45</i> M				
3 SEX <i>FEMALE</i>		4 RACE <i>White</i>		5 DATE OF BIRTH <i>August 26, 1890</i>		6 AGE (In years last birthday) <i>78</i> YRS		7 IF UNDER YEAR MONTHS DAYS HOURS MIN		
7a BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Harford</i> Md				
10 CITY OR TOWN OF DEATH <i>HAURE DE GRACE</i>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Harford Mem Hosp.</i>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housewife</i>		12b KIND OF BUSINESS OR INDUSTRY <i>Homemaker</i>		
13a USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE <i>Md</i>			13b COUNTY <i>Harford</i>		13c CITY OR TOWN <i>Bel Air</i>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <i>9 Dellam Place</i>	
14 FATHER'S NAME First <i>Archer</i> Middle <i>LEE</i> Last <i>COALE</i>			15 MOTHER'S MAIDEN NAME First <i>Mary</i> Middle <i>ALICE</i> Last <i>JONES</i>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or Unknown) <i>NO</i>			16b SOCIAL SECURITY NO <i>215-01-3995 D</i>		17 INFORMANT (NEICE 838-3758) <i>Mrs. Mary Ruth Gilbert</i>		Address <i>816 Rock Spring Avenue Bel Air, Maryland 21014</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiac Arrhythmia</i> <i>4124</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic Cardiovascular disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>years</i>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Partial intestinal obstruction</i>										
19a DATE OF OPERATION <i>NONE</i>		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY Hour A.M. Month Day Year P.M. <i>19</i>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <i>JAN 9, 1969</i> , to <i>JAN 14, 1969</i> , that (I) (we) last saw the deceased alive on <i>JAN 14, 1969</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Charles J. Foley Jr. M.D.</i>		22c. DATE SIGNED <i>Jan. 14, 1969</i>		22d. PHYSICIAN'S NAME (Type) <i>CHARLES J. FOLEY JR. M.D.</i>						
23a BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b DATE <i>JAN. 16, 1969</i>		23c NAME OF CEMETERY OR CREMATORY <i>Churchville Presbyterian Ch. Cem.</i>		23d LOCATION (City or Town) (County) (State) <i>Churchville, Harford Co., Md. 21028</i>		23e ADDRESS <i>W. Broadway & Williams St. Bel Air, Maryland 21014</i>		
24 FUNERAL DIRECTOR <i>Joseph William Foster</i>		25a DATE <i>JAN 16 1969</i>		25b PRECISE TIME <i>10:00 AM</i>		25c SIGNATURE <i>Joseph William Foster</i>				



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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR		
Nellie			Kent			Lowe			JANUARY 26 1969 11 A M		
3 SEX			4 RACE			5 DATE OF BIRTH			6 AGE (In years last birthday)		
Female			White			OCT. 19, 1905			65 YRS.		
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
TYLESVILLE, Md.			USA						Hartford Md		
1d CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Havre de Grace			Hartford Mem Hosp.			HOUSEWIFE					
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE			13b. CITY			13c. INSIDE CITY, IN TS?			13e. STREET AND NUMBER		
Md			Baltimore			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			Perry Hall Manor		
4 FATHER'S NAME			5 MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
HARRY H. KENT			MARY M. RICHARDSON								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b SOCIAL SECURITY NO.			17 INFORMANT			18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))		
No			26-46-7224			FOX HILL ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
			B. ROY LOWE, PERRY HALL, MD.								
PART 1. DEATH CAUSED BY: IMMEDIATE CAUSE (a) Unconsciousness, etiology											
DUE TO, OR AS A CONSEQUENCE OF (b) Not determined											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
(Dr. Palmer was notified at 1 Am on 1/26/69)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
			HOUR A.M. Month Day Year								
			P.M. 19								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION			City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from 1/26, 1969, to 1/26, 1969, that (I) (we) last saw the deceased alive on 1/26, 1969, and that in (my) (our) opinion a death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE			22c. DATE SIGNED								
Edward C. Loo, M.D.			1/26/69								
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS								
Edward C. Loo, M.D.			Havre de Grace, Md								
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
BURIAL			1-28-69			SLATE RIDGE			DELTA YORK PA.		
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
JOHN H. HARRKINS, DELTA, PA.						DATE JAN 29 1969			gcharles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VA 116 (M)
45M 1-69

00920										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										00921									
Items #13b,c,d,&e, Film GH09 2/4/CERTIFICATE OF DEATH																													
1. DECEASED-NAME (Type or print)					First Middle Last					2a. DATE OF DEATH					2b. HOUR														
Mabel					S. Lynch					Month 1 Day 26 Year 69					4:50 PM														
3. SEX					4. RACE					5. DATE OF BIRTH					6. AGE (In years last birthday)					7. IF UNDER 1 YEAR					7. IF UNDER 24 HRS				
Female					W					Aug. 25, 1888					80 YRS					MONTHS DAYS HOURS MIN									
7a. BIRTHPLACE (State or foreign country)					7b. CITIZEN OF WHAT COUNTRY?					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH														
md					USA										Hartford					Md									
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)					12b. KIND OF BUSINESS OR INDUSTRY														
Havre de Grace					Hartford Memorial					Housewife																			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE					13b. COUNTY					13c. CITY OR TOWN					13d. INSIDE CITY LIMITS?					13e. STREET AND NUMBER									
md					Hartford					Nursing					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					38 E. Main St. Old West Windsor Nursing									
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME					16a. WAS DECEASED EVER IN U.S. ARMED FORCES?					16b. SOCIAL SECURITY NO.					17. INFORMANT									
First Middle Last					First Middle Last					No										Mrs. Harry F. Deherty, Wilmington, Del.									
Robert					Smith					Elizabeth McDowell																			
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c))					PART 1 DEATH WAS CAUSED BY					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
41					IMMEDIATE CAUSE (a)					Myocardial Infarction					2. day														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					(b)					Cerebral Thrombosis																			
					(c)																								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					Acute Bronchopneumonia																								
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)																			
					HOUR A.M. Month Day Year P.M. 19																								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION					City or Town County State														
22a. I certify that (I) (this hospital) attended the deceased from 1-24, 1969, to 1-26, 1969, that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE					22c. DATE SIGNED					22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS														
Ernest W. Seiter					Jan 27, 1969					Ernest W. Seiter					RISW6 JUN MD														
23a. BURIAL, CREMATION, REMOVA (Specify)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town) (County) (State)														
Burial					1/28/69					Rose Bank Cemetery					Calvert, Md														
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR					25b. REGISTRAR'S SIGNATURE																			
Hicks Home for Funerals, Elkton, Md.					DATE JAN 30 1969					JAN 30 1969																			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

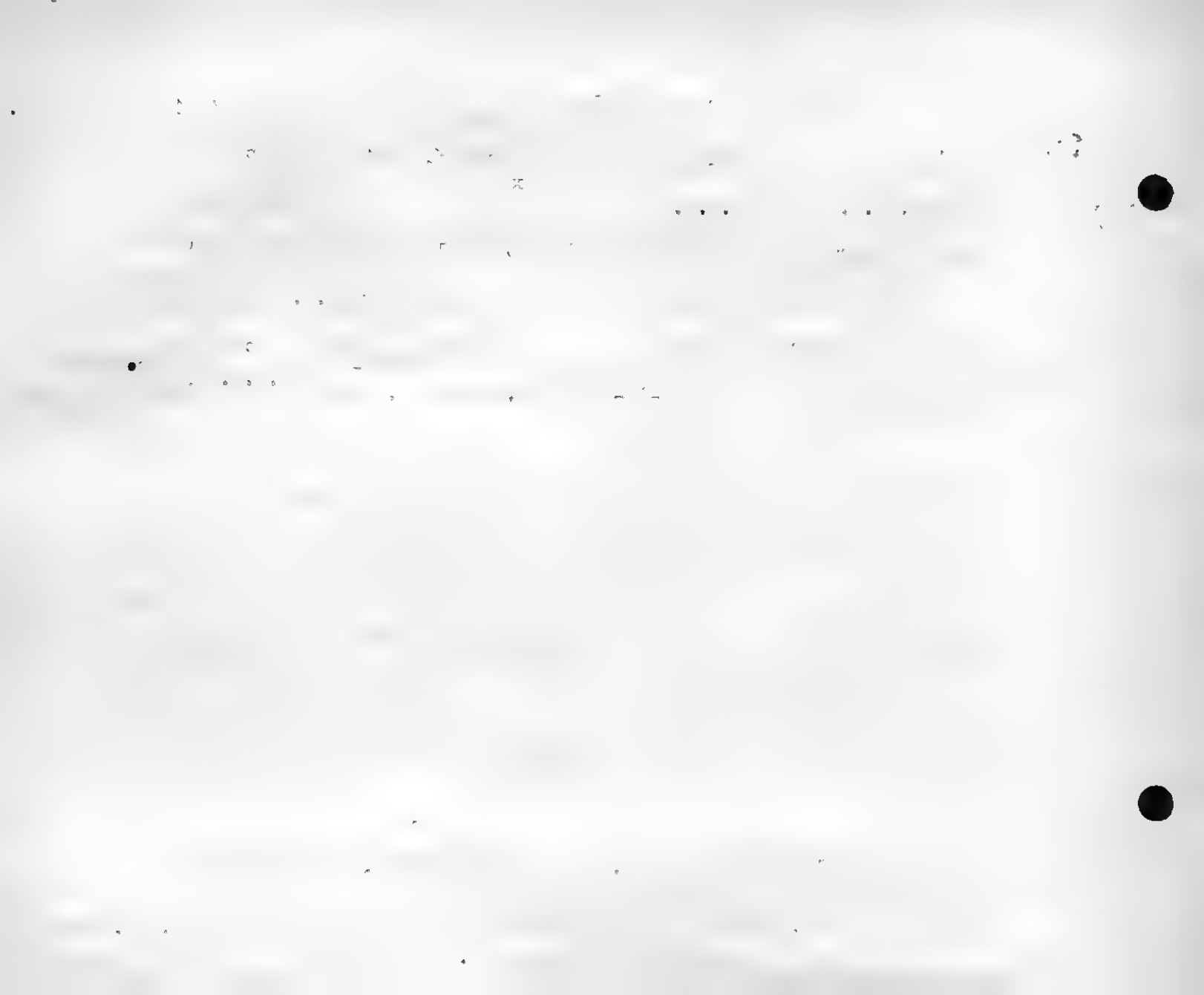
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove the body papers (pages 1, and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

00922		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				00922					
1 DECEASED NAME (Type or print)				First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR	
MARY CATHERINE MALM							January	26	1969	9 ⁰⁰ A.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS HOURS MIN	
Female		White		11/29/1897		71 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Md		U.S.				HARFORD					Md
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
HAURE DE GRACE			HARFORD MEMORIAL HOP			HOUSE WIFE			SAME		
3a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Md			HARFORD		HAURE DE GRACE				613 S. WASHINGTON		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S M.A.D.E.N. NAME			First	Middle	Last
MARTIN				7.	ABBOTT	CATHERINE					MC NULTY
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address					
NO		UNK		MRS FRED SCHOPFER		HAURE DE GRACE, MD 613 S. WASHINGTON ST.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>											
4124											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
(b) <u>Arteriosclerotic Cardiovascular Disease</u>											
(c) <u>Disease</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
<u>Small bowel fistula</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
		<u>Intestinal Obstruction</u>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.				21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 1</u> , 1969, to <u>Jan 26</u> , 1969, that (I) (we) last saw the deceased alive on <u>Jan 26</u> , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death											
22b. SIGNATURE <u>Charles J. Foley Jr. M.D.</u>						22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (Type) <u>CHARLES J. FOLEY JR. M.D.</u>						22e. ADDRESS <u>HAURE DE GRACE, MD.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
<u>BURIAL</u>		<u>1/29/1969</u>		<u>MT. ERIN CEMETERY</u>		<u>HAURE DE GRACE</u>		<u>HARFORD</u>		<u>MD.</u>	
24. FUNERAL DIRECTOR		Address		25a. RECD BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
<u>Severingthorn</u>		<u>San Harude Grav, Md</u>		<u>JAN 31 1969</u>		<u>J. Foley Jr.</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARTLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
00923									
1 DECEASED NAME (Type or print)			First Middle Last			2a DATE OF DEATH Month Day Year		2b HOUR	
Rayvaughn Curtis Miller						January 25, 1969		5:50 PM	
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Male		White		March 5, 1921		47 YRS.			
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
Ashe Co., N.C.		U.S.A.				Harford County,			
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
Havre de Grace		Harford Memorial Hospital		Service Station Att'd		Petroleum			
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER	
Maryland		Harford		Bel Air		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		R.F.D. #1, Box #90	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Sidney Abner Miller			Esther Ethel Cockerham						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give year or dates of service)		16b SOCIAL SECURITY NO.		17 INFORMANT (Name and Address)					
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (at unknown)		WW#2		217-18-5010 Mrs. Lessie H. Miller		Bel Air, Maryland 21014			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u>									
4360 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Essential Hypertension</u>									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
MEDICAL CERTIFICATION									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE		22c. DATE SIGNED							
Dudley Phillips		1/27/69							
22d PHYSICIAN'S NAME (Type)		22e ADDRESS							
Dudley Phillips, M.D.		Darlington, Maryland 21034							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
Burial		Jan. 29, 1969		Bel Air Memorial Gardens		Bel Air, Harf. Co. Md.		21014	
24 FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Joseph William Foster		W. Broadway & Williams St. Bel Air, Maryland 21014		DATE JAN 29 1969		Charles Judge			



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with your files. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

00929

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00924

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or Print)		First	Middle	Last	2a DATE KNOWN OF DEATH		<input type="checkbox"/> Month	<input type="checkbox"/> Day	<input type="checkbox"/> Year	2b HOUR
Norton Harold Newberry					ESTIMATED <input checked="" type="checkbox"/> JAN 2 1969					M
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (In years last birthday)	7 UNDER 1 YEAR		IF UNDER 2 YEARS		2c DATE PRONOUNCED DEAD	
M	W	5-19-09		59 YRS	MONTHS DAYS		HOURS MIN.		Month Jan Day 1 Year 1969	2d HOUR 4P M
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH				
Pa.		USA				Harford		Md		
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY				
Abingdon		605 Long Bar Rd		Construction Inspector - US-Govt.						
13a USUAL RESIDENCE (Where deceased lived, if institution residence before)		13b CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER				
Md		Harford Abingdon		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		605 Long Bar Rd				
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME		16a WAS DECEASED EVER IN U.S. ARMED FORCES?		16b SOCIAL SECURITY NO		17 INFORMANT		ADDRESS
Scott		Winfield Newberry		Jennie -- May		187-03-6347		Norton Scott Newberry, 605 Long Bar Harbor Rd.		Abingdon, Md.
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		(If yes give war or dates of service)		16b SOCIAL SECURITY NO		17 INFORMANT		ADDRESS		
no				187-03-6347		Norton Scott Newberry, 605 Long Bar Harbor Rd.		Abingdon, Md.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion										
4109 DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										
(b) DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?		
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>		21b TIME OF INJURY Month, Day, Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
CAUSE OF DEATH		P.M. 19								
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County		State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspect an <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE		Gerald C. Palmer		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> B. A. in Md.		22b. DATE SIGNED		
EXAMINER'S NAME (Type)		Gerald C. Palmer, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		1-1-69		
ADDRESS (Street, city, town, or county)										
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)		(State)
Burial		Jan. 4/1969		Harford Memorial Gardens		Aldino		Harford		Md.
24 FUNERAL DIRECTOR				ADDRESS				25a FILED BY REGISTRAR		25b REGISTRAR'S SIGNATURE
Howard K. McComas & Son, Abingdon, Md.								JAN 3 1969		Charles Judge

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) Lomia Kansas Frazier Norman		First Kansas Middle Frazier Last Norman		2a. DATE OF DEATH Month 1 Day 7 Year 69			2b HOJR 53		
3. SEX Female		4. RACE Wh.		5. DATE OF BIRTH 15 Aug 1898		6. AGE (In years last birthday) 70 YRS		IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (State or foreign country) Marion, Va.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Hartford			Md
10 CITY OR TOWN OF DEATH Havre de Grace		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Hartford Memorial		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife			12b. KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Md		13b COUNTY Hartford		13c CITY OR TOWN Aberdeen		13d INSIDE CITY - M.F.S? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER Rd 3 Box 258	
14 FATHER'S NAME John Wesley Frazier		First Wesley Middle Frazier Last Frazier		15 MOTHER'S MAIDEN NAME Sally Ambern Norman		First Sally Middle Ambern Last Norman		Address 21001	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		(If yes give war or dates of service)		16b SOCIAL SECURITY NO None		17 INFORMANT John W. Norman R.D.#3 Box 176 Aberdeen, Md.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CEREBRAL VASCULAR ACCIDENT DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ADVANCED ARTERIOSCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH DAYS YEARS
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) PNEUMONIA									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f LOCATION Street or RFD No		City or Town		County State	
22a I certify that (I) (this hospital) attended the deceased for 1-7 12-25, 1968 , to 1-7, 1969 , that (I) (we) last saw the deceased alive on 1-7, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death									
22b SIGNATURE Santiago Leyte-Vidal		DEGREE MD		ATTENDING PHYS <input checked="" type="checkbox"/>		MED DIRECTOR <input type="checkbox"/>		STAFF PHYS <input type="checkbox"/>	
22d PHYSICIAN'S NAME (Type) Santiago Leyte-Vidal, M.D.		22e ADDRESS Aberdeen, Maryland		22c DATE SIGNED 1-8-69					
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 10 Jan 69		23c NAME OF CEMETERY OR CREMATORY Bel Air Mem Gardens		23d LOCATION (City or Town) (County) (State) Bel Air, Maryland 21014			
24 FUNERAL DIRECTOR Kenneth B. Gugo		ADDRESS Tarring Funeral Home		25a REC'D BY REGISTRAR JAN 13 1969		25b REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
20932													
CERTIFICATE OF DEATH													
1. DECEASED-NAME (Type or print) First Middle Last Jaunita Clans PRITT						2a. DATE OF DEATH 1 Month 13 Day 69 Year			2b. HOUR 7:25 PM				
3. SEX ♀		4. RACE Caucasian		5. DATE OF BIRTH April 20, 1927			6. AGE (In years last birthday) 41 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) W. Va.			7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford Md						
10. CITY OR TOWN OF DEATH Harford				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Harford Memorial				12a. USUAL OCCUPATION (Kind of work done during most of work on life, even if retired.) Housekeeper			12b. KIND OF BUSINESS OR INDUSTRY H		
13a. USUAL RESIDENCE (Where deceased lived, if institution Res. before admission) STATE Md				13b. COUNTY Harford		13c. CITY OR TOWN Forest Hill		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Casner Rd.			
14. FATHER'S NAME First Middle Last Romey Winters Pritt						15. MOTHER'S M maiden NAME First Middle Last Susie Hinegardner							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) No				16b. SOCIAL SECURITY NO 227-34-9906		17. INFORMANT Donald R. Pritt, Bel Air, Maryland							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))													
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Inanition, Dehydration</u>													
DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last													
(b) <u>Colo-rectal - colo-entero-caecal fistula</u>													
DUE TO, OR AS A CONSEQUENCE OF													
(c) <u>Radiation Trauma (La Cereix?)</u>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)				21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>17 Dec</u> , 19 <u>68</u> , to <u>19 Jan</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>19 Jan</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE A.W. GRIEBOLEIT						DEGREE ATTENDING PHYS MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 14 January 1969					
22d. PHYSICIAN'S NAME (Type) A.W. GRIEBOLEIT						22e. ADDRESS HARVARD & GRACE, MD							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE 16 Jan. 69		23c. NAME OF CEMETERY OR CREMATORY Harford Memorial Gardens			23d. LOCATION (City or Town) (County) (State) Aberdeen, (Harford) Maryland				
24. FUNERAL DIRECTOR Tarring Funeral Home, Aberdeen, Md. 21001						25a. RECD BY REGISTRAR JAN 16 1969		25b. REGISTRAR'S SIGNATURE Charles J. ...					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR
Elizabeth Kate			Quinn			JAN. 2 1969			3:15 PM
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (n years lost birthday)		7 IF UNDER 1 YEAR MONTHS DAYS	
Female		white		8/3/1911		57 YRS			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Virginia		U.S.A.				HARFORD Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
HAVRE de Grace			HARFORD Memorial Hosp						
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
MARYLAND			HARFORD			HAVRE de Grace		120 Weber St.	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			
Ballard Carter						Ethel Jennings			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT				
No			100-100000000		Rosen D. Quinn 120 Weber St. Harford, Md.				
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c))									
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Cardiac Decompensation									
DUE TO, OR AS A CONSEQUENCE OF (b) A.S. C.V.D.									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
① Post-influenza Pneumonitis ② Bronchial Asthma									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
			HOUR A.M. Month Day Year P.M. 19						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC)			21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 12/20, 1968, to Jan. 2nd 1969, that (I) (we) last saw the deceased alive on Jan 1, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death									
22b. SIGNATURE			22c. DATE SIGNED			22d. PHYSICIAN'S NAME (Type)			
Edward C. Loo, M.D.			1/2/69			Edward C. Loo, M.D.			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
1/4/69			1/4/69		Harford Memorial Cdn. Harford, Md.				
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
James H. Quinn			JAN 6 1969			James H. Quinn			

CERTIFICATE OF DEATH

00933

00928

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		Month	Day	Year	2b. HOUR
Clarence W.				Rake	1			20	69	5:40 PM
3 SEX	4 RACE	5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
m	w	14 July, 1896			72		MONTHS		DAYS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED		9. COUNTY OF DEATH				
W. Va.		USA		NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Harford		Md		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		12a. LSJAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY				
Havre de Grace		Harford Memorial		Barber		Barber Shop				
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
md		Harford		Harford		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		110 Deaver St.		
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO		17. INFORMANT		
Ralph M.		Cassie Balderson, (D)		No		232-28-4437		Jean Harbaugh, Aberdeen, Maryland		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Acute myocardial infarction		Acute myocardial infarction		Acute myocardial infarction		Acute myocardial infarction		5 days		
DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		5 days		
Coronary thrombosis		Coronary thrombosis		Coronary thrombosis		Coronary thrombosis		?		
DUE TO OR AS A CONSEQUENCE OF		DUE TO OR AS A CONSEQUENCE OF		DUE TO OR AS A CONSEQUENCE OF		DUE TO OR AS A CONSEQUENCE OF				
A.S.C.V.D.		A.S.C.V.D.		A.S.C.V.D.		A.S.C.V.D.				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		21d. INJURY OCCURRED				
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		HOUR A.M. Month Day Year				While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		21g. LOCATION				
While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				Street or R.F.D. No.		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from Jan 16th 1969 to Jan 20th 1969, that (I) (we) last saw the deceased alive on Jan 20th 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS				
Edward C. Loo, M.D.		1/20/69		Harford		Harford				
23a. BURIAL CREMATION REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		23e. LOCATION (County) (State)		
Removal		24 Jan. 69		Mt Olive Cemetery		Parkersburg, West Virginia				
24. FUNERAL DIRECTOR		ADDRESS		25a. RECD BY REGISTRAR		25b. RECD BY REGISTRAR				
Tarring Funeral Home, Aberdeen, Md. 21001				JAN 23 1969		JAN 23 1969				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
00931											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR		
Virginia Lenora Renshaw						Month	Day	Year	12:20PM		
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female	White	5-24-90		78 YRS.		MONTHS		DAYS			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Pennsylvania		USA				Harford Md.					
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Hayre de Grace			421 S. Union Avenue			Housewife					
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Maryland			Harford		Abingdon				806 Long Bar Harbor		
14 FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME			First	Middle	Last
James					Milheim	Hulda					Miller
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)			16b. SOCIAL SECURITY NO		17 INFORMANT Address						
No			179-20-5090		Brevin Nursing Home Record Card						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Decompensation and</u>											
DUE TO, OR AS A CONSEQUENCE OF <u>Pneumonia</u>											
(b) <u>Arteriosclerotic Heart Disease</u>											
DUE TO, OR AS A CONSEQUENCE OF <u>Arteriosclerosis</u>											
(c) <u>Arteriosclerosis</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.			21f. LOCATION Street or RFD No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 8-50, 1968, to 1/7, 1969, that (I) (we) last saw the deceased alive on 1/6, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Dante U. Monakil, M.D.</u> DEGREE					ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 1/7/69				
22d. PHYSICIAN'S NAME (Type) Dante U. Monakil					22e. ADDRESS 211 N. Union Ave. Hayre de Grace, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		Jan. 9, 1969		Bel Air Memorial Gardens		Bel Air Harford Md.					
24 FUNERAL DIRECTOR					25a. READ BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Howard K. McComas & Son, Abingdon, Md.					JAN 9 1969		J. J. J.				

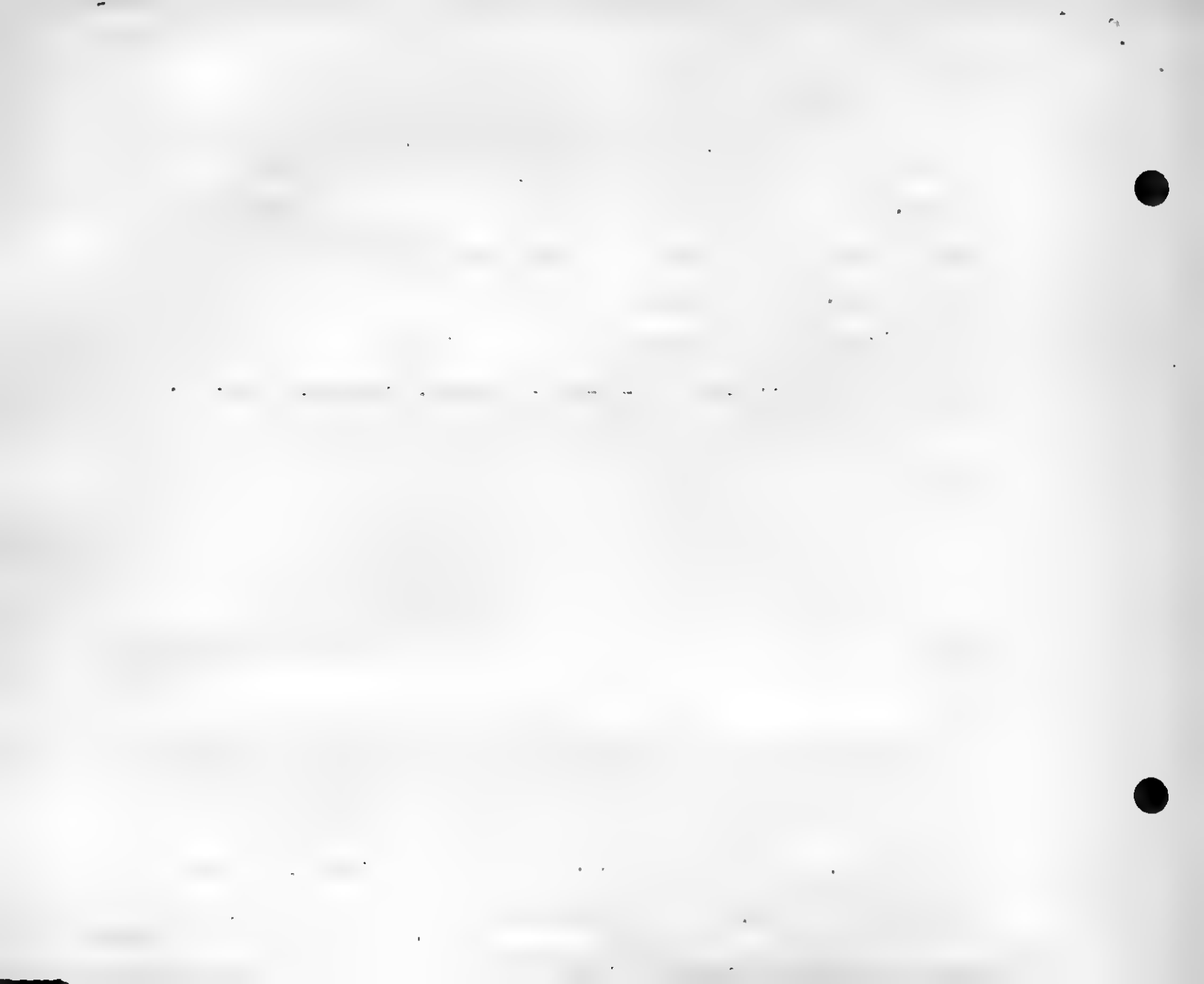
00930

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Benjamin H Sargable			2a. DATE OF DEATH Month 1 Day 14 Year 69			2b. HOUR 6 A M			
3. SEX male		4. RACE white		5. DATE OF BIRTH 05/07/89		6. AGE (In years last birthday) 79 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford Md.			
10. CITY OR TOWN OF DEATH Harre de Grace		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Citizens Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) carpenter		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Harford		13c. CITY OR TOWN Joppa		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 1012 Pulaski Highway	
14. FATHER'S NAME First Michael Middle Last			15. MOTHER'S MAIDEN NAME First Caroline Middle Bechtold Last (D)						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) Yes		16b. SOCIAL SECURITY NO 1911---1912		17. INFORMANT Lula D. Sargable, Joppa, Md. 21085					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chronic obstructive pulmonary disease 4007 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Heart failure and DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes mellitus								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 yr 10 yr	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 11/10 , 19 68 , to 1/14 , 19 69 , that (I) (we) lost saw the deceased alive on 1/13 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Dudley Phillips					ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 1/15/69		
22d. PHYSICIAN'S NAME (Type) Dr. Dudley Phillips M.D.					22e. ADDRESS Darlington, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 17 Jan. 69		23c. NAME OF CEMETERY OR CREMATORY Darlington Cemetery		23d. LOCATION (City or Town) (County) (State) Darlington, Maryland			
24. FUNERAL DIRECTOR Tarring Funeral Home, Aberdeen, Md. 21001					25a. REC'D BY REGISTRAR DATE 20 1969		25b. REGISTRAR'S SIGNATURE [Signature]		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 9 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																													
CERTIFICATE OF DEATH																													
DECEASED NAME (Type or print)			First Walton			Middle S.			Last Scarff			2a. DATE OF DEATH Month Day Year January 3 1969			2b. HOUR 1:45 P.M.														
3 SEX Male			4 RACE white			5. DATE OF BIRTH July 28, 1881			6 AGE (In years last birthday) 87 YRS			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			IF UNDER 24 HRS HOURS MIN														
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA.			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH Harford Md																				
10 CITY OR TOWN OF DEATH Havre de Grace			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Harford Memorial Hosp			12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired) Farmer			12b. KIND OF BUSINESS OR INDUSTRY Farming																				
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland			13b. COUNTY Harford			13c. CITY OR TOWN Forest Hill			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER Rt #11 Road																	
14 FATHER'S NAME Israel Scarff			First Middle Last			15 MOTHER'S MAIDEN NAME Sara Elizabeth Windle			First Middle Last																				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No			(If yes give war or dates of service) ---			16b. SOCIAL SECURITY NO. 219-36-0685			17 INFORMANT Johnson			Address: Hill Road Forest Hill, Md																	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of the rectum</u> DUE TO, OR AS A CONSEQUENCE OF <u>Fragile Pelvis - inoperable</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Carcinoma of the body & tail of</u> (c) <u>the pancreas</u> DUE TO, OR AS A CONSEQUENCE OF PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 21050 3 mos. 3 mos.																	
MEDICAL CERTIFICATION														19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
														21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
														21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)				21f. LOCATION Street or R.F.D. No		City or Town		County		State	
														22a. I certify that (I) (this hospital) attended the deceased from 11:27, 1968 to 3:00, 1969, that (I) (we) last saw the deceased alive on 3 January 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <u>W.H. Sadowsky MD</u>														DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 31 Jan '69											
22d. PHYSICIAN'S NAME (Type) W.H. SADOWSKY MD														22e. ADDRESS 564 Lemm St, Havre de Grace, Md															
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 1/6/1969			23c. NAME OF CEMETERY OR CREMATORY Bel Air Mem. Gardens			23d. LOCATION (City or Town) (County) (State) Bel Air, Harford, Md.			24. FUNERAL DIRECTOR Charles E. Kurtz Jarrettsville, Md.			25a. REC'D BY REGISTRAR JAN 7 1969			25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>											

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or Print)		First	Middle	Last	2a DATE KNOWN OF DEATH			2b HOUR	
William G. Schaeffer					Month Day Year J 1 19 69				
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD
M	W	Feb. 22, 1917		51 YRS	MONTHS DAYS		HOURS MIN		Month Day Year J 2 19 69
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Pa.		USA				Harford			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Edgewood						Cook		Restaurant	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Md.			Harford		Edgewood				2201 Pulaski Highway
4 FATHER'S NAME			5 MOTHER'S MAIDEN NAME						
First Middle Last Samuel -- Schaeffer			First Middle Last Gussie -- Bolton						
6a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO		17 INFORMANT ADDRESS				
no			202-05-1306		Haven, Pa. Cyril Schaeffer, 436 Hess St., Schuylkill				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic CV Disease</u>									
4123 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
2d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County	State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)		22b. DATE SIGNED					
Gerald C. Palmer		Gerald C. Palmer, M.D.		1-1-69					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Removal		Jan. 1, 1968		Geschwindt Funeral Home		Schuylkill Haven Pa.			
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Howard K. McComas & Son, Abingdon, Md. 21009				DATE JAN 3 1969		J Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print) First Middle Last Sophia Hannah Schneider					2a. DATE OF DEATH Month Day Year 1 1 69			2b. HOUR 9:35 M	
3. SEX Female		4 RACE White		5. DATE OF BIRTH 2-28-1906		6 AGE (In years last birthday) 62 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (State or foreign country) Md		7b CITY ZEN OF WHAT COUNTRY? U.S.A		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Harford.			
10 CITY OR TOWN OF DEATH Harford			11 NAME OF HOSPITAL OR INST. TOWN (If not in hospital give street address) Harford Memorial Hospital			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE		12b KIND OF BUSINESS OR INDUSTRY AT HOME	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md			13b COUNTY Harford			13c CITY OR TOWN Beldie		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME First Middle Last Joseph M.M. Barshop			15. MOTHER'S M.A.DEN. NAME First Middle Last Nettie Daum			16a. WAS DECEASED EVER IN ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) NO			
16b SOCIAL SECURITY NO NO			17 INFORMANT MR. REUBEN SCHNEIDER, 18 SOUTH MAIN ST.						
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c))									
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Uremia								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Today	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								(b) Ca Right breast, metastatic	
								(c) Unknown	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC			21f LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 12-30, 1968, to 1-1-1969, that (I) (we) last saw the deceased alive on 1-1-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death									
22b SIGNATURE A. W. GRIGOLEIT					DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c DATE SIGNED 1/1/69		
22d. PHYSICIAN'S NAME (Type) A. W. GRIGOLEIT					22e ADDRESS HARFORD, MD				
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 1-5-1969		23c NAME OF CEMETERY OR CREMATORY ANSHE EMUNAH AITZ CHAIM		23d LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND			
24 FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD					25a REC'D BY REGISTRAR JAN 8 1969		25b REGISTRAR'S SIGNATURE Charles Jones		



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print) <i>Sibblie Shepherd</i>			2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> Month <i>1</i> Day <i>28</i> Year <i>69</i>			2b. HOUR <i>M</i>
3. SEX <i>F</i>	4. RACE <i>W</i>	5. DATE OF BIRTH <i>MAY 21, 1891</i>	6. AGE (in years last birthday) <i>78</i> YRS	IF UNDER 1 YEAR MONTHS <i></i> DAYS <i></i>	IF UNDER 24 HRS HOURS <i></i> MIN <i></i>	2c. DATE PRONOUNCED DEAD Month <i>Jan</i> Day <i>28</i> Year <i>69</i>
7a. BIRTHPLACE (State or foreign country) <i>N. Carolina</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Harford</i>
10. CITY OR TOWN OF DEATH <i>Darlington</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Patrick Rd.</i>		12a. USUAL OCCUPATION (Kind of work done during most of workman's life even if retired) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>
13a. U.S.A. RESIDENCE (Where deceased lived, if institution admission) <i>Maryland</i>		13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>Ashland</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>214 Ashland Rd.</i>
14. FATHER'S NAME <i>UNKNOWN</i>			15. MOTHER'S MAIDEN NAME <i>UNKNOWN</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16b. SOCIAL SECURITY NO. <i>219-10-3037</i>		17. INFORMANT <i>Family Records</i>		ADDRESS <i></i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic Disease</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>4124</i> (b) <i></i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i></i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i></i>						
19a. DATE OF OPERATION <i></i>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <i></i>			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <i></i>		21b. TIME OF INJURY Month, Day, Year <i>19</i> HOUR A.M. <i></i> P.M. <i></i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18) <i></i>		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i></i>		21f. LOCATION Street or R.F.D. No. <i></i> City or Town <i></i> County <i></i> State <i></i>		
22a. I certify that I took charge of the remains described above, held on death resulted from: <i>Natural causes</i> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion
ACTUAL SIGNATURE <i>Gerald C. Palmer</i>		EXAMINER'S NAME (Type) <i>Gerald C. Palmer, M.D.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <i>B. A. M.</i>		22b. DATE SIGNED <i>1-28-69</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>1/31/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Poplar Grove Cern.</i>		23d. LOCATION (City or Town) (County) (State) <i>Pikesville, Md.</i>
24. FUNERAL DIRECTOR <i>John Palmer Sons, Towson, Md.</i>				25a. REC'D BY REG. STAMP <i>FEB 3 1969</i>		25b. REGULAR'S SIGNATURE <i></i>

FOR STATE HEALTH DEPT.

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VR 15ME 15,
10M REV 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH		2b HOUR		
LILLIE			Bell			SINGLETON		Month Day Year 1969 Jan 15 6 PM		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (n years last birthday)	7 IF UNDER 1 YEAR MONTHS DAYS	8 IF UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD		2d HOUR		
Female	White	May 18, 1893	75 YRS			Month Day Year 1969 Jan 15 6 PM				
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Maryland		U.S.A.				Harford Md.				
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
Havre de Grace			Harford Memorial Hospital			Housewife		Home		
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
Maryland			Harford		Aberdeen				General Delivery	
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME							
First Middle Last John Elliott (D)			First Middle Last Mary Duff (D)(
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
No			220-14-7538		Mary Pinckney, Baltimore, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hemorrhage from varicose ulcer-right leg										
1540 DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
MEDICAL CERTIFICATION										
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?		
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year HOUR A.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County State		
22a. I certify that I took charge of the remains described above, held on death resulted from. (Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>)										
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			22b DATE SIGNED				
Gerald C. Palmer			M.D.			1-16-69				
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER							
Gerald C. Palmer, M.D.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
			ADDRESS (Street, city, town, or county)			Bel Air, Maryland				
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)				
Burial		18 Jan. 69		Baker Cemetery		Aberdeen, (Harford) Maryland				
24 FUNERAL DIRECTOR			ADDRESS			25a. RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Tarring Funeral Home, Aberdeen, Md. 21001						JAN 20 1969		[Signature]		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print)			First Middle Last			2a DATE OF DEATH			2b HOUR		
Hugh			E			Smith Jr. 3rd.			JAN. 11 1969 1815-M		
3 SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)			IF UNDER 1 YEAR	
male		Negro		JAN. 11 - 1969			YRS			MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH				
Md.		USA					HARFORD			Md	
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			
Aberdeen Proving Ground				US Kirk Army Hospital				Infant			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INS DE CITY LIMITS?		13e. STREET AND NUMBER	
Md.				Harford		Aberdeen		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2723 E 2nd Ave.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
Hugh Elga Smith, Jr			Linda Marie Blow								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO		17. INFORMANT					
No				N/A		Hugh E. Smith, Jr, 2723 E 2nd Ave, Aberdeen, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY.											
IMMEDIATE CAUSE (a) 7769 Primary Apnea											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
Prematurity											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
		HOUR A.M. Month Day Year									
		P.M.									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION		Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from 11:30 am 6/19/69, to 11 Jan. 1969, that (I) (we) lost the deceased alive on 11 Jan. 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE						DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
Richard H Heller										11 Jan 69.	
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
RICHARD H HELLER, CPT, MC						US KIRK ARMY HOSP, ABERDEEN PROVING GR, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Removal		11 Jan. 69		Hampton National Cemetery		Hampton,				Virginia	
24. FUNERAL DIRECTOR						ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Tarring Funeral Home,						Aberdeen, Md. 21001		JAN 16 1969		Charles Judge	



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MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR				
Sadie Jane Smith						January Month 24 Day 1969			7:45 P M				
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female		White		4 May, 1886			82 YRS.		MONTHS DAYS		HOURS MIN		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH				
Va.			U.S.A.						Harford			Md	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY				
Anne-de-Grace			Harford Memorial Hospital			Housewife			Home				
13a. USUAL RESIDENCE (Where deceased lived if institution Residence before admision) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER	
Md			Harford			Magnolia			YES			Fort Hoyle Rd.	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last										
James Hayes			Mary Blevins										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO			17. INFORMANT			Address				
No			215-54-2172			Frances Blevins, Magnolia, Maryland 21101							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))													
PART I. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) Cardiac Decomposition													
DUE TO, OR AS A CONSEQUENCE OF													
(b) Arterio-sclerotic Cardiovascular													
DUE TO, OR AS A CONSEQUENCE OF													
(c) Cerebral Disease													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)													
19a. DATE OF OPERATION													
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED													
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)													
21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19													
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>													
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)													
21f. LOCATION Street or R.F.D. No. City or Town County State													
22a. I certify that (I) (this hospital) attended the deceased from 1-20, 1969, to 1-24, 1969, that (I) (we) last saw the deceased alive on 1-24, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>Donald H. Monack MD</i> DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> 22c. DATE SIGNED 1-24-69													
22d. PHYSICIAN'S NAME (Type) Donald H. Monack, M.D. 22e. ADDRESS 211 P. Union Ave. Anne Arundel Co													
23a. BURIAL, CREMATION, REMOVAL (Specify)													
Removal													
23b. DATE 25 Jan. 69													
23c. NAME OF CEMETERY OR CREMATORY Rosemont Cemetery													
23d. LOCATION (City or Town) (County) (State) Glade Springs, Virginia													
24. FUNERAL DIRECTOR ADDRESS Tarring Funeral Home, Aberdeen, Md. 21001													
25a. RECEIVED BY JAN 28 1969 25b. REGISTRARS SIGNATURE Judge													



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 1-66
304M REV 1-66

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) First Middle Last <i>Steele T. Snuder</i>			2a. DATE OF DEATH Month Day Year <i>Jan. 12 69</i>			2b. HOUR <i>7 P.M.</i>			
3. SEX <i>Female</i>		4 RACE <i>White</i>		5 DATE OF BIRTH <i>01-23-95</i>		6 AGE (In years last birthday) <i>73</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a BIRTHPLACE (State or foreign country) <i>Mo.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Harford</i>			
10. CITY OR TOWN OF DEATH <i>Harre de Grace</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Citizens Nursing Home</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Post worker</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>U.S.A.</i>			
13a USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE <i>md</i>		13b CITY OR TOWN <i>Harford</i>		13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <i>St Johns Towers Harre de Grace</i>			
14 FATHER'S NAME First Middle Last <i>OTIS AMOS TREADWAY</i>			15 MOTHER'S M A DEN NAME First Middle Last <i>OLEITA VICTORIA BRINLEY</i>						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <i>Yes, na, or unknown</i>			16b SOCIAL SECURITY NO <i>217-46-1793</i>		17 INFORMANT Address <i>Mrs. CLARK CONNELLEY, OAKINGTON, MD.</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebrovascular Accident</i> 4369 DUE TO, OR AS A CONSEQUENCE OF (b) <i>Heart Arrhythmia</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1007</i>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>None</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21f. LOCATION Street or R.F.D. No		City or Town		County	State
22a I certify that (I) (this hospital) attended the deceased from <i>1/15</i> , 19 <i>68</i> , to <i>1/21</i> , 19 <i>69</i> , that (I) (we) lost saw the deceased alive on <i>1/14</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Dudley Phillips</i>				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <i>1/14/69</i>			
22d. PHYSICIAN'S NAME (Type) <i>Dudley Phillips MD</i>				22e. ADDRESS <i>DARLINGTON MD 21034</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>JAN. 15, 1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>WESLEYAN CHAPEL CEM.</i>		23d. LOCATION (City or Town) (County) (State) <i>HARFORD Co. MD</i>			
24. FUNERAL DIRECTOR <i>R. Madison Mitchell, Harre de Grace, Md.</i>				25a. REC'D BY REGISTRAR <i>JAN 16 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
00841										
0039										
1 DECEASED NAME (Type or print) First Middle Last Homer Rouse Sprinkle					2a. DATE OF DEATH Month Day Year January 1 1969			2b. HOUR 2:37 AM		
3 SEX Male		4 RACE White		5. DATE OF BIRTH Oct. 13, 1896		6 AGE (In years last birthday) 72 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a BIRTHPLACE (State or foreign country) VA.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Hartford Md				
10 CITY OR TOWN OF DEATH Havre de Grace			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Hartford Mem. Hosp.			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOSPITAL ATTENDANT, RETIRED		12b KIND OF BUSINESS OR INDUSTRY V.P. M.A. V.A.		
13a USUAL RESIDENCE (Where deceased lived, if institutional residence before admission) STATE Md			13b COUNTY Cecil		13c CITY OR TOWN Port Deposit		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER Box 68	
14. FATHER'S NAME First Middle Last LAFAYETTE S. SPRINKLE			15 MOTHER'S MAIDEN NAME First Middle Last SARAH CELE							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WORLD WAR I			16b SOCIAL SECURITY NO 199-07-7009		17 INFORMANT 3565 TADDEWILL DRIVE, NW WA HAROLD K. SPRINKLE HUNTSVILLE, ALA.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										
PART 1. DEATH WAS CAUSED BY										
IMMEDIATE CAUSE (a) Cerebral anoxia										
DUE TO DR AS A CONSEQUENCE OF										
(b) Pulmonary edema										
DUE TO, DR AS A CONSEQUENCE OF										
(c) ASCVD										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
Hemorrhagic anemia due to pyloric channel ulcer -										
19a DATE OF OPERATION										
19b CONDITION FOR WHICH OPERATION WAS PERFORMED										
20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?										
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										
21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										
21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18)										
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work										
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										
21f LOCATION Street or R.F.D. No City or Town County State										
22a. I certify that (I) (this hospital) attended the deceased from 12-24, 1968, to 1-1, 1969, that (I) (we) lost saw the deceased alive on 1-1, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE A.W. GRIGOLEIT										
22c DATE SIGNED 1/1/69										
22d PHYSICIAN'S NAME (Type) A.W. GRIGOLEIT										
22e ADDRESS HAVRE DE GRACE										
23a BURIAL, CREMATION, REMOVAL (Specify)										
23b DATE JAN. 4, 1969										
23c NAME OF CEMETERY OR CREMATORY HARTFORD MEMORIAL GARDENS										
23d LOCATION (City or Town) (County) (State) HARTFORD Cecil MD										
24 FUNERAL DIRECTOR K. W. Madsen Mitchell										
25a REC'D BY REGISTRAR JAN 3 1969										
25b REGISTRAR'S SIGNATURE Charles Judge										



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00945										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH										240									
1. DECEASED NAME (Type or print) <i>RUFUS G. THOMAS</i>					First Middle Last					2a. DATE OF DEATH Month Day Year <i>JANUARY 11 1969</i>					2b. HOUR 6 ¹⁰ A.M.				
3 SEX <i>MALE</i>			4 RACE <i>White</i>			5 DATE OF BIRTH <i>17 February 1937</i>					6 AGE (In years last birthday) <i>31</i> YRS			7 UNDER YEAR MONTHS DAYS		8 UNDER 24 HRS HOURS MIN			
7a. BIRTHPLACE (State or foreign country) <i>W. VA.</i>			7b. CITIZEN OF WHAT COUNTRY? <i>U.S. #.</i>			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH <i>HARFORD</i> Md										
10 CITY OR TOWN OF DEATH <i>HAVERDE GRACE</i>					11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>HARFORD Memorial Hospital</i>					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Retired</i>					12b. KIND OF BUSINESS OR IND. STRY <i>Concrete Pipe</i>				
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>MD</i>					13b. COUNTY <i>HARFORD</i>			13c. CITY OR TOWN <i>Aberdeen</i>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>643 Market St. 382 North East Rd</i>						
14 FATHER'S NAME First Middle Last <i>Clarence Thomas (D)</i>					15 MOTHER'S MAIDEN NAME First Middle Last <i>Thelma Thomas (D)</i>														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) <i>Yes Korean</i>					16b. SOCIAL SECURITY NO. <i>232-56-8767</i>					17 INFORMANT Address <i>Eleanor M. Thomas, Aberdeen, Maryland</i>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <i>Capillary embolism</i> <i>1579</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																			
MEDICAL CERTIFICATION																			
19a. DATE OF OPERATION <i>12-14-68</i>					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Intestinal Obstruction</i>					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from <i>12-4-68</i> , 1968, to <i>JAN. 11</i> , 1969, that (I) (we) lost the deceased on <i>JAN. 11</i> , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (aid) (did not) view the body after death.																			
22b. SIGNATURE <i>William R. Brendle</i>										DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>					22c. DATE SIGNED <i>1-11-69</i>				
22d. PHYSICIAN'S NAME (Type) <i>William R. Brendle, M.D.</i>										22e. ADDRESS <i>Haverde Grace Md</i>									
23a. BURIAL, CREMATION, REMOVA. (Specify) <i>Burial</i>					23b. DATE <i>13 Jan. 1969</i>					23c. NAME OF CEMETERY OR CREMATORY <i>Calvary Methodist Cemetery</i>					23d. LOCATION (City or Town) (County) (State) <i>Churchville, (Harford) Md.</i>				
24. FUNERAL DIRECTOR ADDRESS <i>Tarring Funeral Home, Aberdeen, Md. 21001</i>										25a. REC'D BY REGISTRAR DATE <i>JAN 14 1969</i>					25b. REGISTRAR'S SIGNATURE <i>Judge</i>				



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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) JOHN WILLIAM TOMLIN			2a. DATE OF DEATH Month Jan Day 9 Year 69			2b. HOUR 10:45 PM	
3. SEX MALE		4. RACE CAV		5. DATE OF BIRTH 9 JAN 1969		6. AGE (in years last birthday) YRS. MONTHS DAYS 5 53	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH HARFORD	
10. CITY OR TOWN OF DEATH ABERDEEN		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) US KIRK ARMY HOSP		12a. USUAL OCCUPATION (Kind of work done during most waking life, even if retired) N/A		12b. KIND OF BUSINESS OR INDUSTRY Infant	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN A.P.G.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER 2742 E. Augusta St.		14. FATHER'S NAME First WILLIAM Middle T Last TOMLIN		15. MOTHER'S MAIDEN NAME First DIANA KAY Middle NICHOLS Last NICHOLS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes give year or dates of service)		16b. SOCIAL SECURITY NO. None		17. INFORMANT William T. Tomlin, Aber Prov. Gd., Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Distress DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 HRS	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Aspiration							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 9 JAN 1969 to 9 JAN 1969 ; that (I) (we) last saw the deceased alive on 9 JAN 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Samuel Kaye		DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 9 JAN 69			
22d. PHYSICIAN'S NAME (Type) SAMUEL KAYE, CAPT, MSC		22e. ADDRESS US KIRK ARMY HOSP, APO, MD					
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 11 Jan. 1969		23c. NAME OF CEMETERY OR CREMATORY Coleman Cemetery		23d. LOCATION (City or Town) (County) (State) Riverside Alabama	
24. FUNERAL DIRECTOR Tarring Funeral Home, Aberdeen, Md. 21001				25a. REC'D BY REGISTRAR JAN 13 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR
JACOB PHILLIP WAITMAN						1 23 1969			4:00 PM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
male		white		7-11-80		28 YRS.			
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
Maryland			U.S.				Harford Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Havre de Grace			Citizen's Nursing Home			Farmer			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER
Md.			Harford		Joppa		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1700 Hanson Road
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
John			--		Waltman	Annie			-- Schillman
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address			
no			213-38-8484-A			Fenie Hein Waltman, 1700 Hanson Road, Joppa, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulm. embolism</u>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>4 yr. Cong. Heart Failure.</u>									
DUE TO, OR AS A CONSEQUENCE OF (b)									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 1</u> , 19 <u>68</u> , to <u>Jan 25</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>Jan 21</u> , 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Lajos Mezei</u>						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) <u>Lajos Mezei</u>						22e. ADDRESS <u>Havre de Grace, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		Jan. 28, 1969		Trinity Lutheran Cemetery		Joppa Harford Md			
24. FUNERAL DIRECTOR ADDRESS <u>Howard K. McComas & Son, Abingdon, Md.</u>						25a. REC'D BY REGISTRAR DATE <u>JAN 28 1969</u>		25b. REGISTRAR'S SIGNATURE <u>William J. Judge</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

00943

00943

1 DECEASED NAME (Type or print) Mary E. Ward.			2a. DATE OF DEATH Month 1 Day 15 Year 1969			2b. HOUR 7:45 P. M.							
3 SEX Female		4 RACE White		5 DATE OF BIRTH Nov. 11, 1882		6 AGE (In years last birthday) 86 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN			
7a BIRTHPLACE (State or foreign country) Md.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford							
10 CITY OR TOWN OF DEATH Harre-de-Grace		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Harford Memorial Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Home maker		12b. KIND OF BUSINESS OR INDUSTRY							
13a USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE Md.		13b COUNTY Cecil		13c CITY OR TOWN Rising Sun		13d ASIDE CITY, TOWNSHIP YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER Calvert Nursing Home					
14. FATHER'S NAME First Charles Middle Ward Last Ward			15. MOTHER'S MAIDEN NAME First Alice Middle Fisher Last Fisher										
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown		16b SOCIAL SECURITY NO. 212-50-3221		17 INFORMANT Mrs Robert Dudley, Medley, Pa.		Address							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO, OR AS A CONSEQUENCE OF hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 20 DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL, BETWEEN ONSET AND DEATH 20	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION Jan 11, 1969		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED to remove the tumor		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from 1-11-69 , 19 69 , to 1-15-69 , 19 69 , that (I) (we) last saw the deceased alive on 1-15-69 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Lee A. Patterson		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1-15-69							
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS 212 W. Preston St., Baltimore, Md.		22f. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 1/18/1969		23c. NAME OF CEMETERY OR CREMATORY St. Mark's Cemetery		23d. LOCATION (City or Town) (County) (State) Perryville Cecil Md.							
24. FUNERAL DIRECTOR Lee A. Patterson		ADDRESS Perryville, Md.		25a. RECD BY REG. STRAR DATE JAN 28 1969		25b. REGISTRAR'S SIGNATURE Robert Dudley							

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00949

00944

1. DECEASED-NAME (Type or print) First Middle Last Charles Leland Winn			2a. DATE OF DEATH Month Day, Year January 29, 1969		2b. TIME FROM 10:30
3. SEX Male	4. RACE White		5. DATE OF BIRTH Dec. 12, 1892		6. AGE (In years last birthday) 76 YRS.
7a. BIRTHPLACE (State or foreign country) Donalds, South Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford County, Md.
10. CITY OR TOWN OF DEATH Bel Air		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 122 Stoneleigh Road		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Agent	
12b. KIND OF BUSINESS OR INDUSTRY Insurance		13a. CITY OR TOWN Bel Air		13b. STREET AND NUMBER 122 Stoneleigh Road	
14. FATHER'S NAME First Middle Last Daniel Henry Winn		15. MOTHER'S MAIDEN NAME First Middle Last Frances Elizabeth Seawright		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes	
16b. SOCIAL SECURITY NO. 216-05-6006		17. INFORMANT (Wife) 838-6892 Mrs. Mary Ruth Winn		Address 122 Stoneleigh Bel Air, Md. 21014	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive CV Disease 4122 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 1-1 , 19 65 , to 1-29 , 19 69 , that (I) (we) last saw the deceased alive on 8-1 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Gerald C Palmer MD		22c. DATE SIGNED Jan. 30, 1969		22d. PHYSICIAN'S NAME (Type) Gerald C. Palmer, M.D.	
22e. ADDRESS S. Main St., Bel Air, Md. 21014		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Feb. 1, 1969	
23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens		23d. LOCATION (City or Town) (County) (State) Bel Air, Harford Co., Md. 21014		24. FUNERAL DIRECTOR W. Broadway & Williams Bel Air, Maryland 21014	
25a. REC'D BY REGISTRAR FEB 3 1969		25b. REGISTRAR'S SIGNATURE [Signature]		25c. REGISTRAR'S NAME [Signature]	

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MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
00950					00945					
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR	
RAY			ELMOR WOODS			JAN 22, 1969			2:00 PM	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR	
MALE		WHITE		19 Feb 1911			51 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
VIRGINIA			USA					WARFORD Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
HAURE de GRACE			WARFORD MEMORIAL HOSPITAL			Bookkeeper			Farm Implemen	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND			WARFORD		BEL AIR				THOMAS RUN ROAD, RD 2	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
Edward N. Woods			Edith Via							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT				
No						M. J. Gaughn Route #1, Bel Air, Md. 21014				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART 1. DEATH CAUSED BY:										
IMMEDIATE CAUSE (a) RENAL FAILURE & OLIGURIA										
5311 DUE TO, OR AS A CONSEQUENCE OF										
(b) MASSIVE INTRAVASCULAR HEMOLYSIS										
DUE TO, OR AS A CONSEQUENCE OF										
(c) ANTIBODY RECALL PHENOMENON TO A LOW FREQUENCY ANTIGEN										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
FAR ADVANCED CHRONIC ACUTE PYELONEPHRITIS										
MARGINAL GASTRIC ULCER & PERFORATION										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1, or Part 2, Item 18.)				
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION				
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>						Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 1/17, 1969, to 1/22, 1969, that (I) (we) last saw the deceased alive on 1/22, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE			22c. DATE SIGNED							
Edward C. Loo MD			1/22/69							
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS							
EDWARD C. LOO MD			HAURE de GRACE, MD							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Removal Burial		25 JAN 69		Evergreen Cemetery		Roanoke, Virginia				
24. FUNERAL DIRECTOR			ADDRESS			24a. DATE BY REGISTRAR		24b. REGISTRAR'S SIGNATURE		
Kenneth B. Gungo			Tarring Funeral Home			JAN 24 1969		Charles Judge		
			Aberdeen, Maryland 21001			DATE				

